Attitudes towards Mental Illness in Turkish and Greek Speaking Cypriot Communities Living in Cyprus

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Abstract

The aim of this thesis was to assess and explore attitudes of the Turkish (TC) and Greek (GC) speaking Cypriot communities towards mental illness. The attitudinal similarities and differences of the two communities were also investigated along with the factors that contribute to these. Despite the negative consequences of stigma noted in previous literature, this is the first collective study to be carried out with these communities.

A mixed method sequential explanatory design was used. A total 519 participants was recruited from the two communities via convenience sampling. Twenty-one of these participants were then interviewed using a one-to one, semi-structured interview technique during the qualitative phase of the thesis. Interviews were analyzed using the Interpretative Phenomenological Approach.

Findings showed a significant relationship between familiarity factor, culture factor and attitudes. Differences between TC and GC participants in terms of these factors were also found. TCs reported significantly less favorable attitudes towards mental illness compared to GCs. They were also found to be more collective in their culture, and reported significantly less one-to-one contact with mental illness compared to GCs.

Four dimensions of stigma were also extracted using a Principal Component Analysis on the AQ-27 scale; Threat, Hospitalisation, Pity and Perceived-Control. Results of the three-step hierarchal model, which was created in line with previous research, showed culture and familiarity as the strong explanatory factors of these four dimensions. While collectivism was found to be a positive predictor of these dimensions individualism and familiarity factors were found to be the negative predictors of them. From the

demographic factors investigated ‘Sex; and ‘Age’ were also found to be significantly predicting the ‘Threat’ and Hospitalisation’ dimensions of stigma respectively. While being a woman positively predicted the Threat dimension, being older positively predicted Hospitalisation dimension of stigma. Knowledge factor was, however, not found to be one of the explanatory factors of the stigma dimensions in this research.

Illuminated in the themes; 1) Community Tightness, 2) Current Cultural Values, 3) Culture and Mental Illness Stigma, 4) Structural Factors and Mental Illness Stigma, 5) Strategies to Tackle Mental Illness Stigma, the IPA analysis of the interview data revealed that the communities’ cultural orientations were related to their perceptions, understanding and explanations of mental illness. In line with the quantitative study’s findings participants also revealed that the structural factors; familiarity with mental illness, policy and regulations around these issues were effective in their understanding of and perceptions about mental illness consequently attitudes towards those with mental health problems.

The results of the qualitative and quantitative studies are further discussed throughout the thesis and a number of important recommendations are given in a hope to diminish stigma of mental illness in TC and GC communities.

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This thesis is dedicated to the people of Cyprus who manage to remain united despite all the challenges that are faced in our divided island.

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Chapter 1: Introduction

1.1 Introduction

The aim of this thesis is to investigate public stigma towards individuals with mental illness within the Turkish and Greek speaking Cypriot communities by assessing the public attitudes towards those with mental illness. The reasons behind public stigma and attitudes within the Turkish and Greek speaking Cypriot communities will also be explored in this thesis.

In order to gain an understanding into the attitudes towards mental illness and stigma towards those who have mental health problems, it is vital for the researcher to initially define the key terms. In this chapter the researcher, therefore, aims to provide a detailed account to the key terms that will be used in this thesis. The chapter, therefore, begins with a detailed explanation of the terms mental health and mental illness. This will then be followed by a critical discussion around mental health-related stigma and looking into the previous work done in the field. Factors highlighted by the previous research in relation to mental illness stigma; education, knowledge and culture will also be discussed.

1.2 Definitions of Mental Illness and Mental Health

According to Kappler and Robinson (2003), it is a difficult task to define mental illness and generally the diagnosis that people receive is the reflection of a professional giving the diagnosis rather than the one who is receiving it. This is because everyone has their own biases including clinicians; therefore individuals have different perceptions and

ideas regarding mental illness. The definition of mental illness is, consequently influenced both by cultural as well as biological factors (Kappler & Robinson2003).

Although there is much debate about the definition of mental illness, the term includes all mental disorders, which may be related to distress, such as depression and anxiety disorders (Power, 2015). It may also affect and change thinking, mood or behaviour, consequently resulting in impaired functioning (Caceda, Nemeroff & Harvey, 2014). Mental Health, on the other hand, is defined as having a good mental functioning that enables people to realise their potentials, adapt and cope with daily life stressors, and maintain good relationships with others (Hoeger & Hoeger, 2016).

Goldman and Grob (2006) also argued that the definition of mental illness could be seen as a continuum between the broad mental health care problems and narrower clinical definitions. According to the National Community Advisory Group on Mental Health (1994), mental health care problems could be seen as problems that may result in an individual disadvantage, dependency and inability to live to one's fullest potential (Boardman, 2010). Since mental illness can influence one's life, the diagnosis needs to be understood within the context of life circumstances as well. In clinical context, on the other hand, mental illness is seen as a symptom, which is related to mood, thinking and cognition. It can also be defined as a behaviour which is the outcome of distress that may cause dysfunction (Ahmedani, Belville-Robertson, Hirsch & Jurayj, 2016).

1.3 Facts about Mental Health

According to World Health Organisation (WHO, 2016) there are more than 450 million individuals around world who have mental health problems. Thirteen per cent of the global

disease burden is caused by mental health conditions as schizophrenia, depression and alcohol dependence. This is more than the burden resulted due to cardiovascular disease and cancer (National Centre for Health Statistics, 2015; cited in Siegel, Miller & Jemal, 2015). It has been noted by WHO (2010) that by 2030 the second highest disease burden will be caused by depression in the middle-income countries. In the past 45 years there has been a worldwide increase in suicide rates (WHO, 2010). It has been reported that more than 90% of individuals who commit suicide have a mental health problem that is diagnosable (Wasserman et al., 2015).

It is, however, not clear why mental illness is still very disabling even though it is commonly experienced, not just in Europe, but around the world as well. According to the McGorry, et al. (2007) even though a great deal is known about mental illness, its treatment and care, it may be hard to apply this knowledge to practice. This may be because of the fact that in some countries there are not many mental health services that are community-based and those who specialise in young or elderly people. It may also be due to the fact that not many countries around the world have effective mental health policies that will help improve the quality of lives of those who are living with a mental health problem by implementing effective strategies to help integrate these individuals into their communities. Due to these issues general public may not be well aware of the true nature of mental health conditions and the treatment options available for these conditions, therefore, many with mental illness face ignorance in their communities. It is also very common for individuals with mental health problems to experience stigma which is an important factor influencing the treatment seeking behaviour (Clement, Schauman & Graham, et al., 2015). Due to the fear of stigma individuals who are in need of treatment do not seek it or fail to complete the

treatment programme (Aphroditi, 2010). It has been noted by Kessler, Berglund and Bruce et al., (2001) that approximately 40% of individuals with severe mental illness receive a treatment that is consistent and this number is likely to be lower in the countries that lack effective treatment services as Cyprus (Georgiades, 2009).

According to many researchers such as Falvo (2013), mental illness is a significant contributor to the every aspect of one's life especially physical and social ones. It is now acknowledged that mental wellbeing is a crucial factor that enables individuals to live satisfying lives consequently affecting societies' wellbeing as well.

Education, for example, is one of the factors that are negatively influenced by mental health problems. Van Der Kolk (2017) argued that childhood mental illness is linked to more severe mental health problems later in life, which may have a negative effect on one's life opportunities. Mental illness may reduce schooling years and the levels of productivity. This in turn may have lifelong consequences on employment, income and other aspects of one's life (Eisenberg, Golberstein, & Hunt, 2009).

According to Cornaglia, Crivellaro and McNally (2012), even though many researchers have established the negative effects of mental illness on education, there have not been many studies that are longitudinal on this subject. They, therefore, conducted a longitudinal study on young people in England to investigate the relationship between poor mental health and education in a longer period of time. The results from their study revealed that students with mental health problems are more likely to isolate themselves, have attention problems and anxiety disorders. Students without any mental health issues, on the other hand, have more positive experiences in school, consequently enabling them to

develop their social as well as intellectual skills. Furthermore, these factors are all linked to high achievement and increased self-confidence. Previous researchers also suggest that having a mental illness effects one's social and personal relationships in a negative way. For example a study carried out by Gureje, Lasebkan and Ephraim-Oluwanuga et al. (2005) in Nigeria with 2040 participants had reported that the willingness of general population to be socially distant from those with mental illness. In their study 83% of the participants reported being scared to start a conversation with and 78% noted that they would not feel comfortable working alongside with someone who has mental illness. Further to these 81% of the participants reported unwillingness to share a room with a person who has mental illness and further 83% of the respondents reported that they would be ashamed of having a relative who is diagnosed with a mental illness. Only 17% of the respondents reported willingness to maintain a social relationship with a person who has a diagnosis.

In support to this Robles and Kiecolt-Glaser (2003) also noted that being diagnosed with a mental illness reduces the quantity and quality of social ties, which has been further linked with loneliness and unwillingness to participate in social engagements and depressive symptoms. Further to this, there is a strong evidence suggesting that people with severe mental illness, as schizophrenia are amongst the most excluded and restricted within the societies (Killaspy et al., 2014).

It has also been argued that mental illness can cause or be caused by social disadvantage (Horwitz & Scheid, 1999) and according to the UK Social Exclusion Unit (2004), individuals with mental illness are the ones most excluded from the society.

In addition to these, Sagie, Eliasi and Livneh et al. (2013) also noted that the link between mental and physical health could not be ignored. Health conditions such as diabetes, hypertension, heart disease and cancer are strongly associated with mental illness. Nylor, Parsonage and McDaid et al. (2012) argued that the relationship between mental and physical health might be caused by mental illness making the symptoms of a chronic disease worse. This is because mental illness may also affect one's ability to seek and receive treatment, personal care, and participate in recovery.

According to the Canadian Institute for Health Information (CIHI, 2008), mind-body connection is often referred to as the link between the mental and physical health (Lim, Jacobs & Ohinma, et al., 2008). It can also be seen as the body's reaction to the way someone thinks, feels and acts (American Academy of Family Physicians, 2004). Biological, emotional and social factors are all effective on the mind and body connection; therefore, all these factors can increase the possibility of experiencing mental illness or chronic physical condition that may then result in a co-existing one. CHIHI (2008) also noted that the individuals who are living with mental illness are more likely to experience physical health problems. It is also the case for individuals with chronic physical health problems that the probability of experiencing mental health problems is increased. For example, Evans et al. (2005) found that mental illness may affect hormonal balances, sleep cycles and the immune system. They also argued that many psychiatric medications might cause individuals to have irregular heart rhythms and gain weight. Due to all these factors, one's chances of experiencing physical health problems as well as mental ones are increased.

Social determinants of health also affect and are affected by mental and physical health (Williams & Wang, 2006). This is because people who suffer from mental and physical problems may face barriers in accessing the needed treatment, finding a job or house and having a strong social network. For example, it is found that people with mental health problems are more likely to be unemployed, have unstable housing and experience isolation. In their study Patten, Williams and Wang (2006) found that people with arthritis are more likely to develop mood and anxiety disorders. They also mentioned that research on individuals with mental illness showed lower rates of arthritis. It is, however, possible these individuals are unlikely to report arthritis due to difficulty in reporting pain (Leucht, Burkard & Henderson et al., 2007).

As all these studies suggested that mental illness might have a negative influence on both personal and social aspects of one's life, it is therefore very important to seek and receive early treatment for such health problems. People with mental health problems are, however, less likely to receive health checks compared to those without any mental health conditions. Furthermore, they are also less likely to seek specialist care or receive surgical treatment even after the diagnosis of a physical condition (Uman, Chambers, McGrath, & Kisely, 2008). According to many researchers, this may be due to the fact that people with mental health problems may have less access to the health treatment centres. Apart from the accessibility to the required services, stigma also plays a significant role in seeking and receiving treatment.

Stigma may prevent individuals to seek help and may result in delayed diagnosis or misdiagnosis of physical conditions. In the case of misdiagnosis, physical symptoms are either ignored or overshadowed by the mental ones (Disability Rights Commission, 2006).

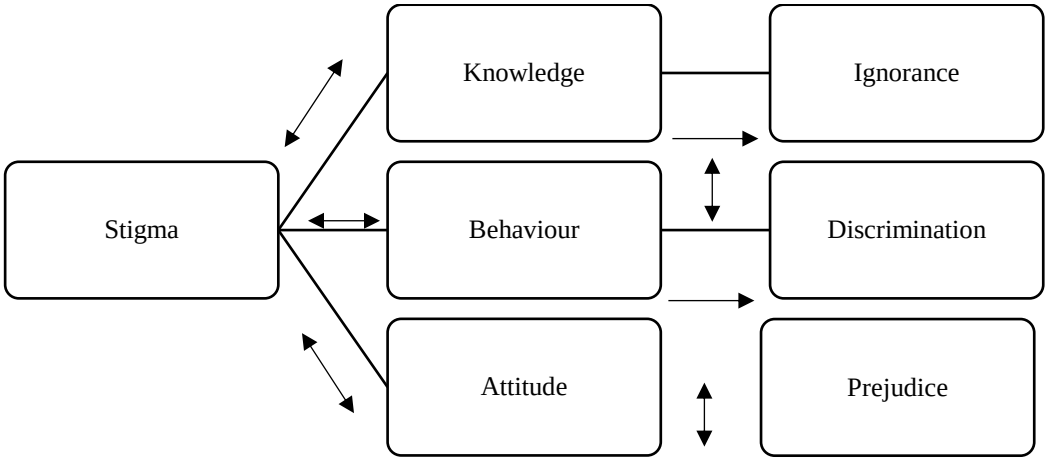
In some cases stigma plays a greater role than the accessibility on receiving the necessary treatment both for mental and physical conditions. According to Papadopoulos (2009), mental illness is still highly stigmatised in most societies, consequently resulting in great difficulties for individuals experiencing mental health problems as well as their families.

In addition to the symptoms caused by mental illness, individuals with these conditions also have to deal with the consequences of stigma. Studies on psychiatric stigma have recently started to emerge and it is important to understand the true meaning of stigma when trying to understand the consequences of it on individuals. The concept of stigma can be generally divided into two; public and self-stigma (Corrigan, 2002). Public stigma refers to the negative perception of the population on mental illness and their reaction to the mentally ill individuals. Self-stigma can be defined as the negative attitudes and beliefs people hold about themselves due to their illnesses (Corrigan, 2002). According to Goffman (1963) the secondary symptom of mental illness is stigma and it affects individuals more than the primary symptoms of it. He further defined stigma as a belief that is held about an individual or a group suggesting that they do not fit the norm (See Chapter 2 for more details). Individuals from different ethnicities, social economic situations, demographical and educational backgrounds may experience stigma at different levels and according to Goffman (1963), there are three different aspects of stigma. The first type is related to the physical aspects of an individual. The second type is based on the personal factors such as personality disorders. The third type is related to the values and the norms of a certain society for example, in certain communities living alone after a divorce may be stigmatized. Kurzban and Leary (2001) noted that individuals who are stigmatized are seen

as a problem and are more isolated than the ones who are perceived as a victim by the society. Even in some conditions that cannot be controlled, such as physical or mental illness, these individuals can still receive significant levels of stigma. Many researchers therefore, argued the importance of understanding all three levels when trying to address the stigma process. Further to these, according to Thornicroft, Brohan and Kassam et al. (2008), in general stigma can be seen as an association between three related concepts; ignorance, prejudice and discrimination (See Figure 1.3.1). All these elements affect peoples' attitudes, and the way they behave towards mentally ill individuals.

Figure 1.3.1

Stigma Process; Interaction between Ignorance, Discrimination and Prejudice



1.4 Components of Stigma

1.4.1 Ignorance

According to Crisp, Gelder, Goddard and Meltzer (2005) in many societies the knowledge about mental illness is very little which may lead to ignorance (See Table 1.4.3.1). For example, a study done by the Thornicoft et al. (2008) noted that when presented with the statement; '*Someone that is not responsible for their own action'*

majority of the society (55%) thought that the person in the statement has mental illness. Armstrong, Kermode, Raja, and Suja et al. (2011) also conducted a study to explore the effectiveness of mental health training on mental health literacy. As a result they found that mental health training was significantly associated with a decreased level on stigmatizing attitudes. Another very recent study, which was conducted by Clement et al. (2012) on public mental disorder education and its effect on stigma levels. In their study, they used two different contact strategies; film based intervention and in-vivo intervention strategy. Film based intervention involved the public watching a film about an individual with mental illness and their carers' stories of recovery and illness. The in-vivo strategy applied the same principle but the carers and actual service users were in the setting where observers watched the video/film. They found a significant reduction on public's negative attitudes, and that there was no difference between the two groups. These findings were supported by Corrigan et al. (2012), who also found a positive affect of the two interventions on attitudes. Their results, however, showed that the in-vivo strategy had greater positive impact on the labelling and stigma reduction. Cotton, Wright, Harris, Jorm, and McGorry (2006) also argued that particularly specific groups that include teenagers should be provided more information about mental illness, and the mental health literacy of the public should be improved in order to reduce intolerance and ignorance that may be caused due to lack of knowledge.

1.4.2 Prejudice

All individuals experience feelings of fear, anxiety and avoidance, regardless of having mental illness or not. Individuals without mental health problems generally experience these feelings when they are in the same environment with individuals who

have mental health problems. People with mental illness, on the other hand, experience isolation, which may cause these feelings (Link, Yang & Collins, 2004). According to Thornicroft and Kassam (2008), even though stereotypes also predict discrimination, prejudice may be a stronger predictor of it. Rose, Thornicroft, Pinfold and Kassam (2007) conducted a study in England on 14 years-old students finding that there were 250 words that were used by these students for mental illness and all of these were negative.

McCauley, Jussim, and Lee (1995) noted that the distinction between stereotype and prejudice should be made. Unlike people who are aware of the certain stereotypes, people who hold prejudice against those with mental illness also agree with these negative stereotypes, such as 'All individuals with mental illness are dangerous'. These individuals also develop negative emotions following the stereotypes such as 'I am scared of them'. Prejudicial attitudes are, therefore, consist of a typically negative view, whereas stereotypes are perceptions (See Table 1.4.3.1).

Due to prejudice, stigmatized groups are faced with emotional responses that are negative such as anger or fear. Herek (2015) noted that prejudice is a response that is cognitive and affective. This is associated with discrimination, which is defined as the behavioural reaction. Furthermore, Weiner (1974) also suggested that prejudicial attitudes, which are related to anger, can actually cause harmful behaviour, such as physical harm to the stigmatized group (Pryor & Boss, 2015). In the content of mental health problems, prejudice that is linked to anger may also prevent help or cause health care services to be replaced with the criminal justice system for these individuals. In addition to these, being scared of individuals with mental illness may result in avoidance consequently reducing the opportunities for these individuals. Individuals who apply the prejudicial beliefs and

attitudes to themselves may also experience self-discrimination. Many researchers also argued that individuals with mental health problems are more likely to experience self-discrimination due to the fear of rejection by others. This also prevents them from benefiting from opportunities that they may have (Tzouvara, 2015).

1.4.3 Discrimination

Thornicoft and associates (2008) argued that there is much research showing the existence of discrimination towards those with mental illness. Discrimination has a negative impact on one's marriage, work, education and social life. Evidence has shown that individuals with mental illness find it hard to get a job, become educated, get married and have children (Petersen et al., 2007; Kidd, Kenny, & McKinstry, 2015).

Corrigan and Thompson, et al. (2003) conducted a study on individuals to understand the discrimination due to race, gender, mental and physical illness and sexual orientation. Their study had two parts: in the first part they assessed individuals' perceptions of discrimination and in the second part they assessed their experiences of discrimination. The results showed that those who have mental or physical disabilities and different sexual orientation mostly experienced discrimination particularly in employment, housing and law. Social psychologists also viewed stereotypes that may cause stigma and argued that public's knowledge is the most effective factor that plays a role on discrimination. This is because knowledge reflects the ideas that are shared by certain people that belong to the same group. According to them, not having enough information about mental illness can cause intolerance and ignorance, negative behaviour and attitudes

may result in discrimination and prejudice towards individuals with mental illness (See Table 1.4.3.1)

Table 1.4.3.1

Comparing and Contrasting the Definition of Public and Self-Stigma

Public Stigma		
	Stereotypes	Beliefs that is negative towards an individual or a group. For example mentally ill individuals are unpredictable.
	Prejudice	Agreeing with the stereotypes and showing an emotional reaction due to it such as fear.
	Discrimination	Behavioural reaction to the prejudice such as avoidance or not employing and individual with mental health problems.
Self-Stigma		
	Stereotypes	Negative beliefs which individuals hold about themselves such as 'I have a weak character'.
	Prejudice	Agreement with these negative beliefs and having an emotional reaction about it such as anger to self.
	Discrimination	Having a behavioural response to the prejudice such as not being able to find a job or a house.

According to Pescosolido (2013), the behavioural reaction of public stigma, which is also known as discrimination can be divided into four concepts; not helping, avoiding, forced treatment and isolated associations. Many researchers argued that public might not help those with mental illness as a result of stigma. Others argued that the social avoidance could also be seen in some societies where individuals do not interact with those who have mental illness. In 1996 the General Social Survey (GSS) conducted a study with 1444 dults in the US. The survey revealed that half of the participants would not want to socialize,

work or have their family member married with someone who has mental illness (as cited in Blumer & Marcus, 2009). Similarly the results from Zorba's (2012) study also found that the Northern Cypriot participants did not want a mentally ill individual as their neighbours. Participants also reported that they would not want their loved ones to be married with an individual who has a mental health problem. Discrimination may also change the public's idea about how to treat individuals with mental illness. There are not many studies that investigated the effectiveness of forced treatment. The GSS survey, however, found that the more than 40% of the participants said that individuals with schizophrenia should be given mandatory treatment. Furthermore, others have argued that those with severe mental illness can be given the best treatment in the isolated institutions, which are separated, from the community (Yanos, Roe, Markus, & Lysaker, 2015).

1.5 Critical Evaluation of the Stigma Theories

Burry (2005) noted that the ability of the community members to view and tolerate individuals with different health conditions varies in different social context and is dependent on several factors; degree of the disruption of social interactions, tolerance shown to the individuals by their families, colleagues as well as the wider community. Mental health has continued to possess a unique difficulty particularly when people "*translate disgust into the disgusting and fears into the fearful"* (Porter, 2002, p.62).

Traditionally, theories of stigma had been problematic, mainly due to these theories placing the problem within the individuals, in this case those who have a mental illness. For example, Goffman (1963) described stigma as a process that is formed due to an attribute of an individual, which is believed to be negative, and socially discrediting, consequently

leading to a spoilt identity. Thus the perceptions of the community members about an individual with mental illness is that he/she has a specific mark/attribute which leads to the person to be labelled and regarded as abnormal or less of a human. Link and Phelan (2001) further expanded this idea in the field of mental illness stigma. They defined stigma as "*the co-occurrence of its components: labelling, stereotyping, separation, status loss and discrimination."* (Link and Phelan, 2001, p.363). Link and Phelan's model explains stigma as a process that allow an individual to be labelled and differentiated from others within the communities. As a result, a social label given to an individual allows distinctions to be made between "us" and "them" or 'Normal' and 'Abnormal'. Once the label is given, individual is stereotyped and separated which leads to discrimination and exclusion from his/her community. Further to these Corrigan (1998) proposed a model of stigma that suggests the relationship between a signalling event that suggests a psychiatric illness such as talking to self and stigmatizing attitudes of the public. All these theories were developed in an effort to explain stigma as a process that occurs due to a unique characteristic of an individual that is negative.

Recently, Corrigan et al. (2004), however, emphasised the necessity of considering a structural model of stigmatization and discrimination. They studied how various systems discriminate against people with mental illness both willingly and unwillingly. Through their studies they proposed that the *'social justice'* factor should be added to the traditional model of stigma, to allow the focus to be shifted from an individual to institutions (Corrigan et al., 2009). Thus they emphasised on the necessity of a structural level analysis when trying to understand the manifestation and maintenance of stigma within the communities.

One of the biggest challenges with this is perhaps finding ways to integrate the concept of stigma into a broader social context that includes structural, political and economical concepts. Adopting sociological traditions as social model of disability when trying to explain stigma of mental illness may help overcome this challenge. Although this model had been heavily criticised for not including mental health it focuses on social constructions of and reactions to disability (Georing, 2015). Rather than attributing disability to individual differences as the traditional models of stigma had, this model explains stigma and disability as concepts that are products of a societal organisation. It further suggests that attitudes, which are rooted in the societies, are actually the products of prejudice or stereotypes (also referred as disablism), and these attitudes withhold individuals from gaining equal opportunities within their communities and to be a part of their own societies (Davis, 2006). The aim of this model is to remove societal barriers/stigma that create inequalities for and restrict the life opportunities of those who are marked as being 'different'. Using this model one may, therefore, suggests that although mental illness may cause impairment of the mind and/or body, a direct casual correlation between impairment and incapacity of individuals cannot be assumed. This is because concepts as disability and incapacity are socially constructed. Considering the social model of disability and Corrigan et al.'s (2004) structural model of stigma it could be argued that stigma is socially constructed that influences the perceptions of the society members on mental health. This can in turn form attributions and assessments, which members of the society make about individuals with mental illness. Both of these may result in prejudice and discrimination that happen at a wider social, cultural, economic, human, political and institutional context. Mulvany (2000), therefore, argued that in order

to be able to relate personal experiences to structural issues one must study barriers placed by the environment that individuals live in.

Stigma towards mental illness is existent around the world; studies from the Western and Non-Western world and the United States suggested that people do hold stigmatizing attitudes (Tsang, Angell & Corrigan, et al., 2007). According to researchers, it is not only the general public that holds these attitudes; trained professionals also have them (Jahnke, Philipp & Hoyer, 2015). For example a study, which was carried out, by Arkan, Bademli and Duman (2011) in Turkey showed that health professionals also hold stigmatizing attitudes towards individuals with mental illness. Similar to Arkan, Bademli and Duman's (2011) study, previous research which was done within the last ten years also found that the attitudes of the health professionals to be very refusing and judgmental towards psychiatric patients.

Previous researchers also noted the varying nature of mental illness stigma between the non-Western and Western cultures (Angermeyer, MCarta & Matschinger, et al.,2015). Angermeyer et al. (2015) argued that Western attitudes towards mental illness might be less severe compared to the non-Western cultures. Fabrega (1991), on the other hand, suggested that attitudes in Asian and African countries are less severe. She, however, noted that it is not clear whether this is due to the limited research in this area or the effect of culture that does not encourage stigma. According to Coutre and Penn (2003) in Islamic communities attitudes towards mental illness is more positive. This had also been supported by Çiftçi, Jones and Corrigan (2013) who noted that compared to the Western communities, Islamic communities show less discriminatory behaviour towards those with mental illness as mental health problems are understood in terms of God's will. Discriminating these

individuals from the communities are, therefore, seen as defying the will of God; *'Allah'.*

There is, however, much research showing the existence of stigma in these communities. For example, Zorba (2012) conducted a pilot qualitative study in Northern Cyprus, which is an Islamic society. In her study she used a qualitative technique to investigate the attitudes of the general public towards mental illness. Results showed that the stigma exists in Northern Cyprus and people generally held negative attitudes towards individuals with mental illness. For example, mentally ill individuals are generally perceived as unpredictable and dangerous. Furthermore, most of the participants noted that having a neighbour with mental illness would make them feel insecure. Another study which was carried out by Savrun, Arıkan and Uysal et al., (2007) in Turkey also looked at the stigmatizing attitudes towards individuals with mental illness and the impact of gender on these attitudes. Their participants were final year university students from Turkey. Results indicated high levels of stigma and a significant difference between the male and female students in their stigmatizing attitudes. According to this study, female students showed significantly lower stigmatizing attitudes towards those with mental illness than the male participants. The socio-demographic factors were also effective on these attitudes. For example, female participants with higher levels of education were less stigmatizing. In addition to these in some Islamic societies mental illness can also be understood as God's punishment, which in turn may increase discrimination and stigma towards these individuals (Chan, Cao & Gao, 2015). Following these it is clear that the stigma does most probably exist in every culture, religion and society. It is, therefore, very important to carry out more cross-cultural studies in order to understand the reasoning behind these attitudes and develop theories and interventions to reduce the stigma of mental illness.

1.6 Factors behind Stigma of Mental Illness

Much research has been carried out within the field of mental illness and stigma that looked at the possible reasons for the stigmatizing attitudes. The first one is that people with mental illness are generally shown as murderous maniacs who need to be feared of in media (Aracena, 2012). Some people might also think that individuals with mental illness do not have the adult perception and they are childlike.

Individuals with mental illness may also be blamed for their illness and some people may be seeing them as responsible for their illnesses due to their weak character. In a survey, which included 2000 English and American citizens, Corrigan and Watson (2002) noted three negative perceptions of individuals with mental illness. The first one was 'fear and exclusion' and according to these studies people think that individuals with mental illness should be feared of and should not be integrated into the community. The second perception was 'dictatorship' and it suggested that those with mental illness are not responsible; therefore, they should not be allowed to make any life decisions by themselves. The last one was 'compassion' which suggests that individuals with mental illness are childish and they should be taken care of.

Corrigan and colleagues (2000) noted that stigma also exists for other conditions such as physical problems but it is significantly higher for the individuals with mental illness. Unlike those with mental illness, individuals with physical disabilities are not generally seen as responsible for their condition. For example, mental illness is generally linked to drug addiction and criminal acts, therefore, these people are seen responsible for their illness. Research has found that individuals with mental illness receive less sympathy

due to these attitudes that are blaming (Pickard, 2011). Public members may also display anger towards these individuals as they may think that such individuals do not deserve help (Thornicroft, 2011).

1.7 Self-Stigma

Apart from the public stigma individuals with mental illness generally experience low self-esteem and confidence (Herek, Gillis, & Cogan, 2015). These individuals may internalize ideas and beliefs, which suggest that they should not be valued as much due to their illness and this internalized process is referred as self-stigma (Herek, Gillis, & Cogan, 2015). In general, studies have focused on the negative effects of self-stigma and a study, which was conducted in Scotland by Mackay, Bradstreet, McArthur, and Dunion, (2015) has found that many individuals with mental illness experience self-stigma. In support to this McArthur and Dunion (2007) carried out a study that showed two thirds of their participants have felt like mental illness ruined their lives. 59% of the participants argued that they blame themselves and were not satisfied with the fact that they had mental health problems. 44% of the participants noted that they have experienced stereotypes as a result of their mental illness and 59% of them did not want to talk to others, as they do not want to bother anybody with their mental health problems.

1.8 Consequences of Public Stigma on Individuals with Mental Illness

Individuals with mental illness have a great disadvantage due to stigma and may not be able to benefit from social, cultural, and economical opportunities and regulations. Stigma discriminates people from others in the society and these individuals are generally seen as “out” groups (Hatzenbuehler, Phelan, & Link, 2013). Even after the perceived

abnormal behaviours disappear individuals with mental illness are still stigmatized and their lives are still affected (Hatzenbuehler, et al., 2013).

For example, those returning to work after their treatment are not trusted, and seen as less likely to succeed. Mora-Rios, Ortega-Ortega, and Natera (2015) also noted that as social stigma increases self-stigma occurs as well. Individuals who receive less support from their families, friends and colleagues have a sense of rejection and isolation. This may then lead individuals to have less confidence, self-esteem, avoid treatment and have low quality of lives. These factors are, however, all effective in mental health treatment and may worsen one's symptoms.

Hansson, Jormfeldt, Svedberg and Svensson (2013) also noted that mental health professionals do not differ from the society in regards to stigma. For example in Lauber, Anthony, Ajdacic-Gross, and Rössler's (2004) study on social distance towards those with mental illness found no difference between the psychiatrists and society members' attitudes. They, however, found that compared to the general population psychiatrists and health professionals were less hesitant about allowing individuals with mental illness to take care of a child, get married with their relatives and rent them a house. Interestingly this study also found that both psychiatrists and general population did not mind working and being a neighbour of someone with mental illness. Mukherjee and colleagues (2002) also compared medical doctors, medical students and general public in their attitudes towards mental illness finding no differences. Sartorius (2002), however, noted that mental health professionals play an important role on educating and breaking the taboos about mental illness. It is, therefore, very important to work with psychiatrists to reduce stigma. This was also supported recently by other researchers such as Goldbach, Amaro,Vega, and Walter

(2015) who also suggested that mental health professionals also play an important role in reducing self as well as public stigma. He

According to many researchers, it is important to adopt and facilitate different strategies when trying to reduce stigma of mental illness. Work Psychiatric Association (WPA) (1996), started a program to educate the society about schizophrenia and the possible effects of stigma. According to Bahar (2007) these programs are very effective and should not be used to reduce stigma towards schizophrenia, it should be used for other mental illness.

1.9 Various Approaches to Fight Mental Illness Stigma

According to Evans-Lacko, Gronholm, Hankir, Pingani, and Corrigan (2016) public stigma can be minimized by adopting three approaches; education, protesting and increasing contact. Protesting the way which mental illness is viewed (aggressive and imprecise) may be the one way to challenge the stigma. When protesting there should be two targets which are the public and the media. Media needs to stop representing mental illness as dangerous and as something to be feared of. Public, on the other hand, should stop believing these views about mental illness. Betton, et al. (2015) and others argued that stigma and stereotypes about mental illness have lessened in the societies where protesting took place. Even though protesting may reduce negative attitudes towards mental illness, it does not really promote positive attitudes towards mental health problems either.

Education, on the other hand, can actually promote and increase the sympathy towards individuals with mental health problems. Much research had been done in this area, which showed the effectiveness of education on attitudes towards mental illness. For

example, Cook, Purdie-Vaughns, Meyer, and Busch (2014) found that individuals who have more knowledge about mental illness are less likely to display stigma and discrimination. Armstrong et al. (2011) conducted a study to explore the effectiveness of mental health training on mental health literacy. As a result they found that mental health training was significantly associated with less attitudes that were stigmatizing. Furthermore, many researchers agreed that the mental health education can also reduce the stereotypes that are negative and are effective on the wide range of individuals such as college students, adolescents, and general public and even for those with mental illness. To be able to minimize the stigma it is also important for the public to be exposed to mental illness. According to Corrigan and Watson (2002), being exposed to mental illness can be effective on reducing the negative attitudes towards those with mental illness. In a study carried out by Vezzoli, Archiati and Buizza et al. (2001) it was found that individuals who have never interacted with individuals with mental illness held more feelings that were negative compared to the ones who knew someone with a mental health problem. It could be argued that exposure to mental illness may help discredit stereotypical beliefs and myths that surround mental illness; it is his/her fault, he/she is dangerous or unpredictable. This in turn may lead to more understanding and positive feelings as compassion, which is believed to encourage helping behaviours consequently reducing discrimination and stigmatization of persons with mental illness.

1.10 The study's context: Mental Illness Stigma in Turkish and Greek speaking Cypriot communities of Cyprus

This study is particularly focusing on Turkish and Greek speaking Cypriot societies. As will be discussed in Chapter 2 few studies that had been carried out with the Greek and

Greek Cypriot participants who live abroad reported the existence of high levels of stigmatising attitudes towards individuals with mental illness (Papadopoulos, Leavey & Vincent, 2002; Papadopoulos, 2009). No previous research has, however, been carried out with the Turkish speaking Cypriot community so the nature and the level of mental illness stigma is unknown. Studies from neighbouring countries who have also been influential on the Turkish and Greek speaking Cypriot communities of the island in societal and cultural arenas; Greece (Tzouvara & Papadopoulos 2014) and Turkey (Sarıkoç & Öz, 2016), however, noted the existence of mental health related stigma within their communities.

As noted earlier in this chapter considering the negative consequences of mental illness stigma on individuals, their relatives as well as the wider community, it is important to address attitudes towards mental health problems in each communities in order to be able to implement effective interventions and treatment programs that will support the recovery, and integration of individuals with mental health problems into their communities. Such research would help wider societies to accept these individuals, give them a chance, acknowledge their existence, improve the policies covering them and improve their quality of life, consequently, enabling them to benefit the society.

1.11 Conclusion

To conclude, as discussed in the beginning of this chapter stigma of mental illness is wide spread around the world. Mental illness stigma is understood in terms of 3 interacting elements; stereotypes, prejudice and discrimination. Many factors play a role on development of these elements consequently stigmatizing attitudes towards those with mental health problems across communities; knowledge, culture, familiarity and policies.

Previous research had shown that although stigma of mental illness is widespread, the way it is displayed as well the amount of it varies across communities. It is, therefore, necessary to carry out community specific studies in the field. Such studies carry great importance as stigma negatively influences every aspect of one's life. It should, therefore, be further investigated in order to be able to find effective interventions to diminish it within the societies. There are many unknowns about stigma of mental illness in Cyprus particularly in relation to the levels and the way it manifest in Turkish and Greek Cypriot communities. This is mainly due to a lack of research carried out in the island. As a result very few efforts are being spent in order to reduce stigma across the island. It is, therefore, vital to carry out studies that aim to explore stigma of mental illness in great detail in Cyprus.

For this reason the next chapter of this thesis will provide a detailed literature review that is available in the field of stigmatization of mental health and illness. Studies that particularly looked at the impact of knowledge, familiarity and culture will be included in order to further conceptualise the concept of stigma towards individuals with mental illness. Further to these studies carried out in the neighbouring countries; Turkey and Greece that have also been influential on the Turkish and Greek Cypriot communities respectively. This will be done in an effort to gain an initial understanding to how and why stigma of mental illness may manifest in the Turkish and Greek Cypriot communities.

Chapter 2: Literature Review

2.1 Introduction

The components of stigma had been highlighted in Chapter 1; ignorance, prejudice and discrimination (Thornicroft et al., 2007). Previous research suggests namely 3 societal factors; knowledge, cultural orientation and familiarity play a significant role on these elements. For example lack of knowledge within the societies about mental illness results in ignorance and negative stereotypes (dangerousness) to be developed about these conditions (Kinyua & Njagi, 2013). This in turn can lead to the development of stigma and practices that are discriminatory (inequalities in social arenas as employment and education). Societal and cultural norms and values can also determine the behaviour that are deemed to be acceptable in specific communities, therefore, the degree of discrimination and stigma towards people who display these unacceptable behaviour (Mackie, Moneti, Shakya & Denny, 2012). Finally familiarity and awareness can play a vital role on diminishing negative stereotypes, which can also help minimise prejudice and discrimination components of mental illness stigma within the communities (Lloyd, 2013). The next

section of this chapter will, therefore, provide an overview of the literature that looked at the impact of these factors on attitudes towards mental illness consequently stigma.

2.2 Cultural Studies on Attitudes towards Mental Illness

Cultural studies of mental illness stigma emphasize the importance of studying culture as understandings and interpretations of mental health and illness vary from one to another. As well as influencing public's attitudes towards individuals with mental illness, culture has been reported to be influencing one's attitudes towards self, help-seeking behaviour or lack of it (Olafsdottir, Martin & Long, 2017; Choudhry, Mani, Ming & Khan, 2016; Ahmedani, 2011; Pescosolido, 2013).

According to these researchers environmental change, immigration, ethnic origin and the values that are held by certain communities may play a significant role on one's attitudes towards mental illness (Alegria, Atkins, Farmer, Slaton, & Stelk, 2010). Kurzban and Leary (2001) noted that there is a clear association between stigma and societies' norms and expectations, and stigma towards mental illness may also differ even within the same group. Every society has their own unique norms and expectations from their members and studies in the filed suggest that discrimination and stigmatization may occur if one's behaviour is not seen as normal and in line within the society's norms (Ciftci, 2013). Furthermore, Kurzban and Leary (2001) also stated that this is the socio-cultural pattern of the stigma process that suggests the levels of stigma increases during the social interactions if the individual's behaviour and social identity is seen undesirable.

Moran, Abramson, and Moran (2014) noted that one could identify cultural differences through a set of cultural characteristics also known as dimensions. Hofstede has

proposed five dimensions in his research on International Business Machine (IBM) workers from 50 different countries in 1970. The first one is known as 'Power Distance' and it refers to the different ways which individuals use to solve their problems. 'Uncertainty Avoidance' is the second concept that refers to the stress levels of the society that is due to uncertainty. The third dimension is 'Masculinity versus Femininity' and it refers to the roles which women and men adopt in different societies. The fourth dimension is 'Long Term versus Short Term Orientation' which is linked to people's choice of focus; past, present or future. Arguably the most important and well-known dimension of Hofstede is 'Individualism versus Collectivism' and this dimension refers to the common groups, which individuals integrate into. As stated in Chapter 1 one of the main aims of this thesis is to assess attitudes towards individuals with mental illness within the Turkish and Greek speaking Cypriot communities. The "Individualism-Collectivism" dimensions will, therefore, be used in order to be able to identify the cultural orientations of the Turkish and Greek speaking Cypriot communities in Cyprus. Attitudes towards mental health problems will further be explored from a cultural perspective using the Individualism-Collectivism dimensions.

2.3 Explanation of the Individualism and Collectivism Dimensions

According to Hofstede (1998) two opposite cultural orientations are individualism and collectivism. This dimension deals with the degree to which people in a society are integrated into groups. Individualism is higher in developed and Western countries and collectivism is higher in Eastern countries such as Japan and China. In his study on IBM employees, he found that people from US, Australia, Great Britain, Canada and

Netherlands were the most independent, in other words individualistic. People from Venezuela, Colombia, Pakistan, Peru, and Taiwan, on the other hand, were the most inter-dependent (collectivistic). Hofstede (1994) also argued that people from individualistic cultures are more concerned about their own "I" identity whereas collectivistic ones are more concerned with the "We" identity. People from individualistic cultures are more open, direct and definite, compared to collectivistic individuals who may internalize their thoughts and feelings making them less explicit (See Table 2.3.1).

Table 2.3.1

Individualism versus Collectivism

Individualist	**Collectivist**
Everyone is responsible for taking care of themselves and their immediate family	People are born in extended families therefore responsible for the extended family members as well
"I" conscious	"We" conscious
Need privacy	Belonging is important
Being open about ideas is healthy	Harmony must be kept in every condition
Disobedience of rules leads to feelings of guilt	Disobedience leads to shame
Education is a tool to improve economic status and self-worth	Education is a way to gain social acceptance

2.3.2 Horizontal-Vertical Dimensions of Individualism & Collectivism

Although individualism and collectivism constructs are good indicators of culture, some question their reliability (Singelis, Triandis, Bhawuk & Gelfand, 1995). Singelis et al.

(1995) argued that the collectivism-individualism constructs are too broad, which according to Cronbach (1990) creates a problem in regards to fidelity. Fidelity refers to the accuracy of information obtained from the participants. As the two cultural constructs are too broad it is difficult to obtain high measurement reliability and so the fidelity levels of the measurement reduces (Sivadas, Bruvold, & Nelson, 2008). Another limitation of using collectivism-individualism constructs is that the individualism-collectivism scale was developed in America and thus when it is used with other cultural groups some very specific factors extracted previously, such as self-reliance may not emerge as clearly. Sinegel et al., (1995) argued that one could not classify community members as being either a full collective or individualist. For example Triandis (1986, 1998) argued that there are many kinds of Individualism and Collectivism. To him, American individualism is different from Swedish individualism just as Korean collectivism is different from the Israeli kibbutz one. Although there is not a clear cut amongst these constructs, they do offer explanations to the researcher in regards to certain groups' behavioural tendencies in certain situations or contexts thus allow making some predictions about future behaviour.

For the reasons highlighted above, in his later work Triandis (1995) also highlighted the importance of making the distinction between vertical (VI) and horizontal (HI) individualism, and horizontal (HC) and vertical (VC) collectivism. Within the HC community members self emerges as a part of the in-group, and the members of the in-group are perceived as being very similar and equal to each other. This orientation emphasises interdependence and equality amongst in-group members. In communities that are VC self also emerges as a part of the in-group, however, the members of the in-group are not perceived as being equal. Thus inequality is accepted and so some in-group

members are seen as more superior. Within this orientation sacrificing self needs and desires for the needs of the larger group is often emphasised (Triandis, 1995).

As shown in table 2.3.2.1, within the HI communities self emerges as a separate entity and it is seen as same as the others. In the vertical individualist (VI) groups self is independent, however, is also accepted as being different than others. In such cultures being competitive is given importance. For example in a factor analysis carried out on individualism-collectivism constructs of the American students, the most important factor was found to be self-reliance with competition (Triandis et al., 1988). As a result of his study, Triandis argued that United States and France are examples of VI societies where as Sweeden and Australia were classified as being more HI. Further to these while India and traditional Greece were classified as VC, Israeli kibbutz were classified as being HC (Triandis, 1995).

Table 2.3.2.1

Vertical-Horizontal Individualism/Collectivism Cultural Dimensions (Adapted from Singelis, 1995)

		Vertical	**Horizontal**	
	Collectivism	**Individualism**	**Collectivism**	**Individualism**
Self	Interdependent	Independent	Interdependent	Independent
Others	Different from self	Different from self	Same as self	Same as self
Authority	High	High	Low	Low
Equality	Low	Low	High	High
Freedom	Low	High	Low	High
Political	Communalism	Market Democracy	Communal living	Democratic Socialism

System (Rural Communities)

2.4 Perceptions and Explanations of Mental Illness

Traditionally in most cultures mental illness had been viewed in the context of religion and spirituality (Bartlett, 2016). For example in some cultures such as in Afghanistan and Egypt, mental illness is explained in terms of possession of evil spirits (Ng, 2007; Hanwella, de Silva, Yoosuf, Karunaratne & de Silva, 2012). In many ancient civilizations as Egypt and Greece it was traditionally believed that individuals who showed symptoms of mental illness were possessed by bad sprits (Kurian, 1980). In the ancient times the bad sprits were forced out through direct physical attacks on individual's body; biting or starvation (Kurian 1980).

Up until the 18th century such demonological explanations of mental illness were also evident in the Western world as England. According to Shimon (2011) hospitals dedicated for mental illness at a time were more concerned about spirituality than providing a cure for individuals who had mental illness. Similar to the non-western communities, in England the general belief was that mental illness was caused by demonic possessions and if individual with mental illness was to be left alone in the community the demons would attack other members of the public. Such beliefs were also evident amongst the practitioners at the time. For example treatment of mental illness at Lancaster Asylum in 1840 included chaining, hand and leg cuffing. In the mid-18th century, however, such

beliefs started to fade away with capitalism and increased numbers of professionals working in the field. New explanations of mental illness were also introduced in this era. For example John Locke argued that individuals with mental illness did not lose the ability of reasoning but they had wrong ideas in their head that made them do wrong propositions. As a result mental illness was seen as a loss of rational truth, rather than an individual being possessed by demons (Shimon, 2011).

Although these explanations started to fade away particularly in more modern and developed countries as a result of effective anti-stigma interventions, they still exist in some of the less developed areas of world; where witchcraft and voodoo are important aspects of the local culture as Haiti and some parts of Africa. (Ng, 2007; Hanwella, et al., 2012).

In other more traditional cultures such as Vietnam, public may explain mental illness in terms of individual being cursed or Karma or in terms of devil's eye. For example in Vietnamese culture there is a strong belief about Karma and thus mental illness is seen as a punishment of the individuals who may have sinned in their previous lives (Weiner et al., 2013). Further to these in Japanese (Subramaniam et al., 2017) and Turkish (Taskin et al., 2003) cultures mental illness is explained in terms of character weakness or bad upbringing thus resulting in stigma being experienced by individuals as well as their families.

There are many explanations of mental illness with many variations; spiritual and religious beliefs, the notion of save face, of control and threat. The next section of this chapter will, therefore, provide a review of the studies that looked into these explanations and their impact on attitudes towards mental illness.

2.4.1 Religious and Spiritual Beliefs

A literature review carried out by Abdullah et al. (2011) showed that in some American Indian tribes no stigma was attached to mental illness. According to Boyd (2008) these tribes did not distinguish between physical and mental illness and they tend to see individuals' characters as a reflection of their sprits. It could, therefore, be argued that in these tribes due to such spiritual beliefs, individuals with mental illness may be perceived as being spiritually more gifted consequently reducing stigma. In support to this Girma et al., (2013) carried out a study to assess public's attitudes towards people with mental illness (PWMI) and the factors associated with it in Southwest Ethiopia. They recruited 845 participants who were randomly selected to complete the Community Attitudes towards Mentally Ill (CAMI) scale. The results of the regression analysis showed that most of the participants (75%) believed in the possibility of recovery from mental illness. The participants also reported factors as poverty, and stress as being the main causes of mental illness. Further to these participants who scored high on perceived supernatural causes, perceived psychosocial and biological causes reported to have significantly lower levels of stigma. Although more research is needed in the field, this unique finding of Girma et al.'s (2013) study suggests that when people have an explanation for mental illness it leads to a reduction in stigma levels. Parallel with this there are some literatures, which suggest that stigma arises as a result of fear and lack of explanation about one's illness (Thornicroft, 2006; Sartorius & Schulze, 2005). As reported in Girma et al.'s (2013) study supernatural causes can, therefore, help explain the cause of one's behaviour as well as condition which then help reduces fear caused by the uncertainty and ambiguity of the condition consequently leading to a lower levels of stigma (Thornicroft, 2006; Sartorius & Schulze, 2005).

Although some argue that spirituality can lead to a reduction in stigma levels there are studies that show the opposite impact of it. For example Abdullah and Brown (2011) reported that ethnic and cultural minorities as well as the more religious groups as white Christians, generally hold less favourable attitudes towards those with mental illness. To them, religious groups are more conservative and, therefore, have less tolerance for deviance. For this reason they explain mental illness using spiritual etiologies and endorse spiritual treatments for individuals with mental health problems (Lyles, 1992; Cinnirella & Loewenthal, 1999; Leavey, 2010; Payne, 2009). For example a study carried out by Igbinomwanhoa, James and Omoregba (2013) in Benin City, Nigeria showed the relationship between negative attitudes towards mental illness and the use of spiritual beliefs as explanations for mental health problems. For their study they recruited 107 clergy of the Muslim and Christian faiths who were asked to complete a demographic form and the Community Attitudes towards Mental Illness (CAMI) scale. Results showed that the majority of the sample reported a desire for individuals with mental illness to be separated in residential facilities outside the city (63%). It was also found that the majority held Pentecostal beliefs (more than 50%) about mental illness as 'mental illness is caused by lack of faith and possession of sprits' (Igbinomwanhoa, et al., 2013). Parallel to this Young et al. (2003) found that the majority of the pastors believed that individuals with depression or anxiety could cure themselves via becoming more faithful. Although there are conflicting findings about the impact of religiosity and spirituality on attitudes towards mental illness, it could be argued that the conservative nature of these groups may lead to less tolerant attitudes towards individuals with mental illness.

2.4.2 The Notion of Save Face and Social Prestige

Further to this, according to Abdullah e t al. (2011) in some cultures there is a heavy emphasis on the notion of 'Save Face'. For example in Asian cultures that are commonly classified as being collective emphasis is put on the conformity to societal norms, self-control and social prestige (Anthony et al., 2013). As a result mental illness is seen as deviance from norm and a source of shame that leads to individuals and their families to loose face in front of their communities (Anthony et al., 2013). Such explanations are more evident in collective Asian cultures, as well as Greece and Turkey.

It could be argued that the importance given to societal prestige makes members of the society to want to obey the societal rules and norms. Having a mental illness, may, therefore, be seen as a potential factor that violates these norms consequently damaging one's reputation. For this reason members of the public are more likely to stigmatise those with mental illness, and individuals with these conditions are more likely to fear disclosing their mental health problems as well as being more reluctant to seek professional help.

In support to this a study carried out by Papadopoulos (2009) showed ethnic differences in attitudes and levels of stigma towards mental health. For the purpose of his study researcher recruited 305 people from four different ethnic groups; 75 White-English, 77 Greek/Greek Cypriot, 78 American and 75 Chinese. Participants were asked to complete demographics, attitudes towards mental illness, personal knowledge and experience levels of mental illness as well as a cultural questionnaire. Findings of the study showed that the American group held the lowest levels of stigmatizing attitudes followed by the white-English participants and Greek/Greek Cypriot group. Chinese participants, however, held the most stigmatizing attitudes towards mental illness. Cultural orientations had, therefore, been highlighted as one of the important factors playing a role on attitudes shown by

different ethnic groups of this study.

When looked at their cultural orientations American and English participants were found to be scoring significantly higher on the individualism scale compared to Chinese and Greek/Greek Cypriot participants who scored significantly higher on the collectivism scale. It was also found that Greek and Greek Cypriots were more likely than white-English and Americans to deny having a family member with mental illness. They were also found to be more likely to prefer dealing with mental illness inside the family and only seek help when symptoms were no longer manageable due to the fear of losing face and being stigmatized within their communities. As discussed above, collective values that suggest the interdependence, centrality of family and group harmony (See 2.4.1) may have further discouraged individuals from communities with such orientation to hide away their illness in order to protect their social prestige and avoid stigma.

Further to these the Vertical Collectivist orientation of the Greek (Triandis & Vasillou, 1972) and Chinese (Sinegel, 1995) cultures might have resulted in higher levels of stigma being attached to mental health problems as highlighted in Papadopoulos's (2009) study. This is because as mentioned earlier in this chapter (See 2.3.2.1) in the VC societies there is a hierarchal system where some are seen as being more powerful than others. Social prestige in these societies may, therefore, be an indication of power and status, thus people may be more likely to avoid being associated with mental illness via discriminating these individuals, not acknowledging the existence of these conditions or not discussing them openly in their communities which leads to stigma.

2.4.3 Deviant Behaviour and the Threat Perception

The differing levels of tolerance showed to the deviance from the norm and disconformity with the societal norms may also result in varying levels of stigma across different cultural groups. In more individualist cultures as UK and US diversity and deviation is more welcomed (Papadopoulos, 2009). This is because self is defined as being independent from others and personal goals are valued more than the group ones (See Table 2.3.1) (Hofstede, 2008) and thus deviance from the norm may be seen as a threat.

Within the literature the idea of threat is understood in terms two different sources; tangible threat and symbolic threat (Crandall & Morriarty, 2011). Tangible threat refers to a threat to one's physical safety. Symbolic one, on the other hand, is a threat to the society by damaging the social, political and/or spiritual functioning (Crandall & Moriarty, 2011). Classification of these two distinct threats allowed researchers to predict stigma associated with mental illness. Symbolic threat can be explained in relation to Weiner's (1995) theory of responsibility attribution. According to Stangor et al. (2000) symbolic threat forms when one is perceived as being unable to control their actions due to their mental illness. This is then accepted as a threat to the way which society functions. Perceptions of ability to control one's illness may, therefore, cause blame consequently resulting in prejudice (anger) and discrimination (punishment) particularly in collective societies. For example, Yang, et al. (2013) argued that in Chinese culture lack of self-control might be also seen as immoral because self-control is deemed necessary for group togetherness that is a key characteristic of a collective society (Triandis, 2002). This idea could also partly explain the results found in Papadopoulos's (2009) study where collective groups reported more stereotypical believes in regards to unpredictability of individuals with mental illness which subsequently resulted in these groups to also report higher levels of fear and desire to be

socially distant (behavioural component of stigma) from these individuals.

2.4.4 Perceived Cause of the Illness

Moreover, as well as determining what is normal and what is abnormal, therefore, threatening, culture and cultural beliefs also affect the way different societies perceive the causation of mental illness. For example Nakane, Jorm, and Yoshioka, et al.'s (2005) study showed that Australians generally attribute mental illness to genetics, allergies and/or other infection related diseases while Japanese individuals explain such conditions in relation to nervousness and personality weakness. This was also supported by the Kurumatani, et al.'s (2004) study that compared young adults' beliefs about the causes of mental illness. In their study Kurumatani et al., (2004) compared adults from Hong-Kong and England finding that those from Hong- Kong attributed the cause of schizophrenia to social factors, whereas English youths explained such condition as genetics. In addition to this, a study from Turkey also showed that in the rural areas 60% of the participants were found to attribute the cause of schizophrenia to personality weakness (Taskin, Sen & Aydemir et al. 2003).

According to Kendler and Prescott (2006) the role of genetic explanations on attitudes towards mental illness is widely researched by previous researchers. For example, Rusch, Todd and Corrigan (2010) argued that knowing biogenetic factors, which may play a role on mental illness could lead to reduction in stigma. This is because it takes the responsibility off the person experiencing mental health problems. In their article, they argued that some of the widely known mental health advocacy organizations such as National Alliance on Mental illness (NAMI) adopt the biogenetic model of mental illness in their campaigns that aim to reduce stigma held towards those with mental illness.

According to Lindley (2011), the anti-stigma campaigners around the world had traditionally used the biogenetic model of mental illness in an effort to reduce stigma towards mental illness. Furthermore, according to Illes et al., (2008) care providers for the individuals with mental illness believe that use of the brain images when trying to explain the diagnosis of mental illness will take the responsibility associated with the individuals consequently reducing public as well as self-stigma. Hill and Sahhar (2006) also suggested that using genetic counselling with individuals who have mental illness would lead to reduction in stigma levels too. Following these studies many researchers, have argued that understanding the biogenetic model of mental illness will improve the public's attitudes on this matter.

This view has, however, been criticized by many as some argued that overemphasizing the genetic cause of mental illness also known as 'Genetic Essentialism' can actually worsen the attitudes which in turn increases stigma levels (Spriggs et al, 2008). Genetic essentialism suggests that having or not having the crucial gene is the starting point of stigma towards individuals with mental illness. This is because; separation between what is considered to be 'normal' and 'abnormal' is determined by the existence or absence of a particular gene (Phelan, 2005). Although medical model of mental illness can help reduce the blame placed on individuals, members of the general public can, also think that genes are essential for human beings, consequently making mental illness inescapable and unchangeable for the carriers of that specific gene. Furthermore, Yang et al. (2010) suggested that genetics are seen as more serious contributors to mental health stigma compared to the social causes as work stress. They argue that according to genetic essentialism individuals will not be as willing to mix with the ones who have mental

illness, marry them or have children with them if they attribute the cause of illness to the genetic factors. In support to this study conducted by Phelan, Cruz-Rojas and Reiff (2010) found that people who attribute the cause of schizophrenia to the genes are less likely to marry individuals with schizophrenia, as they believe it is transferable and more persistent.

Moreover a study carried out by Ozmen, Ogel, Aker, Sayduğu, Tamar and Boratav (2004) in east and west Turkey also showed the influence of perceptions about mental illness and attributions of the causes of it on attitudes towards depression. For their study 707 participants were recruited and they were represented with a vignette that described a person with depressive symptoms as loss of appetite and interest, and insomnia. Participants were then given an attitude scale to complete in order to assess their perceptions about and attributions of depression. It was found that those who perceived depression as a disease also reported higher levels of aggression and desire to be socially distant from those with this condition. They were also more likely to report that individuals with depression cannot make decisions and should, therefore, not be free in the community. Further to these, participants who thought that depression was a result of personal weakness or social problems also reported higher levels of social distance and noted that they should be hospitalised for the benefit of the society. Interestingly, however, those who attributed the condition to somatic symptoms reported higher levels of positive attitudes towards those with depression. When looked at the findings of this study it could perhaps be argued attributing mental illness to somatic causes as headache and loss of appetite rather than genetic and personal ones make such conditions to be perceived as being less persistent and more treatable like any other physical illnesses as diabetes. It could also be noted that being aware of the genetic explanations does not necessarily mean that people will be able to

articulate or relate to such information. Somatic symptoms as headache and loss of appetite in the case of depression, however, could be thought as more relatable and so may play a role in increasing sympathy and helping behaviour consequently reducing stigma towards individuals with mental illness.

Similar findings had also emerged in a cross sectional study carried out by Zissi (2006) in Greece. For the purpose of this study 100 community members were recruited who were represented with series of vignettes. Both qualitative and quantitative data were collected in relation to how general public interprets and attributes mental illness. Results showed that overt psychotic symptoms of schizophrenia as delusions and hallucinations are attributed to genetic causes while less overt symptoms of mental disorders were attributed to emotional problems triggered by environmental factors. It was also found that participants who attributed the cause of illness to genetic factors also reported more willingness to be socially distant from those with mental illness. It could be argued that overt symptoms that are observable, signal deviation from what is considered to be normal. As discussed earlier in this chapter explaining mental illness with genetic causes along with perceiving it as a deviation from norms can cause in higher levels of stigma in cultures that are collective as Greek and Turkish. This may also explain the reason behind the authoritarian and restrictive attitudes found in Greek and Greek Cypriot participants towards individuals with mental illness compared to English participants in a study carried out by Papadopoulos, Leavey and Vincent (2002).

Looking at the studies that were carried out with participants from Cyprus and the neighbouring countries it is possible to suggest that perceptions around mental illness are negative. This seems to be partly because of the culturally shared beliefs around mental

illness as such conditions being due to genetic and personal weaknesses. Culturally constructed stereotypes in regards to individuals with mental illness as being dangerous, unpredictable and unintelligent seem to also exist in the Greek, Turkish and Greek Cypriot communities. Although there seems to be a concern towards individuals with mental illness in these communities, due to the considerations about the safety of the general public as well as the societal order, these concerns are likely to be overshadowed and stigma towards individuals with mental illness is likely to increase (Papadopoulos, Leavey & Vincent, 2002).

2.5 Mental Health Literacy and Mental Health Related Stigma

As well as cultural concerns other factors as mental health literacy have also been shown as an important factor that plays a role on stigma towards individuals with mental illness. According to many researchers the link between mental health literacy and stigma cannot be missed. Evidence suggests that if the mental health literacy of the society is increased, this will lead to a reduction in stigma (Henderson & Evans-Lacko, Thornicroft, 2013).

An Australian Professor Anthony Jorm was the first person to introduce mental health literacy in 1997. Initially, Black (2002) defined mental health literacy as one's ability to obtain, access and use basic information regarding health, enabling individuals to make the right decision regarding their health. This definition was then expanded to include both social and cognitive abilities that influence decision-making. In the World Health Organization (WHO, 2004) health promotion glossary, it has been defined as including social and cognitive factors that enable individuals to access, acknowledge and use the

information in order to improve their health and maintain it at a good level (Kickbus, 2001). Furthermore, in the literature mental health literacy has been divided into three levels; functional, interactive and critical (Nutbeam, 2000). The first level includes basic literacy skills, which are reading and writing. The second level includes advanced social and cognitive skills allowing individuals to gather information from several different sources, process it and use it to change situations. Finally, level three involves using the information to gain control over the condition. The expanded definition of health literacy can, therefore, be seen as a continuum ranging from basic skills to the analytical ones. It also includes not just personal but also social and environmental concepts. Improving health literacy, therefore, is believed to benefit an individual well being as well as the societal one.

Research in this field has recently started and although health literacy has been widely searched and models have been created, this is still lacking in the field of mental illness. The first aspect to be looked at is the public's knowledge and beliefs about mental illness. Recognition of mental illness carries a great importance when it comes to being able to seek the correct treatment and also when guiding someone-else (Jorm et al., 2006). Many studies have been carried out in the West in order to assess how able the members of the general public are in recognizing mental illness. These studies generally require participants to read a vignette about someone who is showing symptoms of mental illness or substance use. Following this participants are generally asked several questions in order to see if they can clearly identify and label the illness.

Results from the earlier studies have shown that not many people can actually provide the correct name for mental health conditions even though they know it is a mental

health problem. For example, Jorm, et al., (1997) found that only 39% of the Australian population were able to correctly label depression. They also found that only 27% of this population correctly identified and labelled schizophrenia. Another study conducted by Lauber, Nordt, Falcato, and Rossler, (2003) on a representative sample of a Swiss population only 40% were able to recognize depression as an illness and this figure was 74% for the schizophrenia. Furthermore, in America Link, Phelan, Bresnahan, Stueve, and Pescosolido's (1999) study found that participants were only able to identify schizophrenia and major depression from the vignettes when they were asked to rate the likelihood of an individual in the vignette having a mental illness. Highet, Hickie, and Davenport (2002) also noted that a survey from Australia showed that most of the participants did not perceive mental illness as a health problem. People chose depression more frequently when they were asked to name the mental health problem from the vignette. In addition, it was also found that this population did not consider conditions such as dementia, substance abuse and schizophrenia as mental health problems. These early studies have shown that mental health literacy was lacking in many communities around the world, which can be the contributor to the high rates of mental illness stigma associated with such conditions.

It has been, however, noted that the recognition and awareness of mental health problems have improved over the years. Studies carried out in Australia between 2003 and 2011 had consistently showed that public's recognition of mental health conditions as depression had improved over the years (Jorm, 2006; Jorm 2012). This improvement was also reported in the developing countries as the urban (Wang et al., 2013) and rural areas of China (Yu et al., 2015).

Recently Jorm et al. (2015), however, emphasised on the necessity for more efforts

to be spent in the communities in order to improve mental health literacy. This is mainly due to the fact that although mental health literacy has been found to be increase globally over the years, mental illness stigma is still prevalent. Since the introduction of the‘Mental Health Literacy’ concept by Jorm in 1997 educational interventions that aimed to increase mental health literacy had focused on educating public about the neurobiological basis of the illness (Malla, Joober & Garcia, 2015). Although blame attributed to individuals with mental illness and their families had been reduced to some extent as a result of this, the neurobiological view had led to more pessimistic outlook in the public mind. This may have strengthened the already existing perceptions of dangerousness and unpredictability. It, therefore, seems like increased knowledge in relation to genetic/neurobiological basis of mental illness has shifted the blame from individuals to the genetic make-up. Finding something else to blame, however, does not seem to be helping when trying to fight stigma of mental illness. In order to reduce stigma general public should start understanding the true nature of mental illness rather than blaming it on either to the genes or the individual. It should, therefore, be made clear by the educational interventions that heredity is not destiny, and changes in the brain and behaviour as a result of mental illness is reversible with correct treatment. As well as increasing willingness to get treatment, such educational interventions will also allow public to have a more optimistic prognosis on mental illness consequently reducing stigma.

2.6 Familiarity and Mental Health Related Stigma

Another factor that had been commonly associated with stigma of mental illness

was contact and familiarity (Angermeyer et al., 2004; Corrigan et al., 2001; Moon et al., 2008). A recent study conducted by Nee and Witt (2013) aimed to assess how different types of mental illness elicited varying levels of predicted criminality and compared this with factors which might also cause a negative response, specifically, a criminal history and social disadvantage. They recruited 243 participants who were represented with six different vignettes. Three of these were in relation to mental illness (alcohol dependency, depression/anxiety or schizophrenia). They then assessed the influence of having a mental illness, criminal history and disadvantage of background on the perception of crime, sympathy, trust and rehabilitation. In addition to this, Nee and Witt (2013) also examined participants' age and previous contact with mental illness and/or criminal acts in order to investigate whether previous contact has any impact on crime perception, trust and rehabilitation. Results showed that participants' rated the likelihood of someone with mental illness committing crime significantly higher. In relation to familiarity, this study also found that previous contact and familiarity had a positive impact on attitudes for both mental illness and crime; increasing sympathy, trust, and rehabilitation. It should, however, be mentioned that these feelings were higher for mental illness.

Parallel with this many researchers also showed the positive impact of familiarity on mental illness stigma. For example Unnever and Cullen, (2009) argued that stigma levels towards mental illness is reduced if the familiarity is increased because similarity enables greater tolerance consequently reducing negative attitudes and stigma. Nee and Witt (2013), therefore, suggested that in order to reduce stigma levels towards mental illness, public should be made more aware of these issues which will make them more familiar with these conditions.

There are, however, conflicting views on how familiarity might affect mental illness stigma. As well as showing the positive influence of it some studies also showed the negative impact of familiarity on mental illness stigma. In a study carried out by Crisp, Gelder, Rix, Meltzed and Rowlands (2000), it was found that familiarity actually increased some of the stigma outcomes such as dangerousness. They, therefore, argued that as well as familiarity the feature of it is important when it comes to mental illness stigma. Similarly another study was carried out by Angermeyer, Hozlinger and Matschinger (2009) in Germany showed that although familiarity with and mental health literacy of mental illness improved over the eight years, public's desire to be socially distant from those with mental health problems has also increased.

These studies suggest that familiarity gained through various sources can have a differing impact on attitudes. Familiarity with mental illness can form through literacy, media or one to one contact. As discussed previously in this chapter familiarity through media can actually increase stereotypes around dangerousness and unpredictability of individuals with mental illness, which results in more desire to be socially distant. As discussed in Smith's (2015) paper this is because individuals with mental illness are generally displayed as violent and undesirable members of the community by the media. In addition to this, as well as negatively displaying individuals with mental illness media also displays those who work in the field of mental health negatively. They are generally viewed as unprofessional and untrustworthy within the media, which creates negative attitudes and stigma surrounding mental illness as well as its treatments (Smith, 2015).

As noted by Crisp, et al. (2000) the type and quality of familiarity with mental illness is more important when trying to fight stigma to it. According to researchers as

Malla, Joober and Garcia (2015) social contact that refers to hearing lived experiences of individuals with mental illness from first voice seem to be the most effective strategy in reducing stigma of mental illness. This is a qualitatively different type of contact from media or literacy based ones (Knaak, Modgill & Patten, 2014). Social contact had been found to be effective in disproving stereotypes (ignorance), reducing negative feelings as anxiety and fear (prejudice) and increasing positive feelings as empathy and compassion. It had also been shown to be effective in increasing more positive outlook on mental illness and its treatments consequently resulting in reduced willingness of the public to be socially distant from those with mental illness (discrimination) and lower levels of stigma (Maranzan, 2016).

2.7 Previous Research done with Cypriot Population on Mental Health Related Stigma

Although limited there are some studies that show the existence of negative attitudes towards mental illness within the Greek speaking Cypriot community. For example, Livingston, et al. (2002) conducted a study on older immigrants in the UK including the Greek Cypriot population. They aimed to assess the use of health services by older immigrants compared to the British-born ones and to examine the relationship between service use and health difficulties. They found that Cypriot immigrants had the highest use of medical services for both mental and physical health conditions amongst all the participants. Cypriots were also the ones who were more likely to experience depression and report the somatic symptoms for it. None of the Cypriot participants, however, agreed on using psychiatric services and they were more hesitant to take psychiatric medication. This is believed to be due to high levels of stigma that surrounds mental illness within the Greek speaking Cypriot community.

This was also evident in a qualitative study carried out by Charis, et al. (2016) on the experiences of Greek Cypriot individuals living with mental illness. They interviewed ten participants living with mental illness in regards to their health conditions and social implications of it. Similar to the findings of Livingston's (2012) study results of this study also showed that participants were unwilling to take psychiatric medication and reluctant to report their emotional problems due to the fear of stigma. To most of the participants in Charis et al.'s (2016) study taking psychiatric medication was something to be ashamed of and was not acceptable for the Greek speaking Cypriot community, which again is thought to be related to the importance given to social prestige (See Section 2.5.2).

Considering the findings of these studies it could be argued that as well as the understandings of mental health conditions, representations of them are also different and generally somatic in the Greek Cypriot community. In addition to this, previous research in the field noted that the tendency to report somatic symptoms of mental illness as headaches is influenced by social and cultural factors including stigma (Shrivastava, Johnston & Bureau, 2012). It could, therefore, be argued that the higher rates of somatic symptoms being reported by the Greek speaking Cypriot community members who have mental illness is because their community members are more familiar with such symptoms and they, therefore, are less likely to be stigmatized. The somatic representation illness can, therefore be thought as a way to avoid stigma in such communities.

Parallel to this an international qualitative study carried out by Rose, Willis and Brohan, et al. (2011) aimed to assess the prevalence of stigma and discrimination experienced by those living with schizophrenia. Seventy five participants were selected from 15 different countries; Brazil, Bulgaria, Cyprus, England, Finland, France, Greece,

Italy, Lithuania, Malaysia, Romania, Slovakia, Slovenia, Turkey and the USA. Results of the interviews were analysed using thematic analysis. In general, stigma and discrimination was experienced by all of the participants, which had a negative impact on their lives (Rose, et al., 2011). Thus suggesting the widespread nature of mental illness stigma and discrimination around the world. For example, one of the themes that emerged following the analysis of the interviews was 'Avoidance'. A participant from Cyprus reported that once his illness was known during high school, his friends cast him out from their social circle. He also mentioned being mocked by one of his teachers in the class. Another participant from Cyprus also felt that he was treated differently and attacked by his friends after his illness was known. In addition to these, a participant from Cyprus also mentioned being avoided by the members of the public who knew her illness. Referring back to the 'Save Face' notion it could perhaps be though that out casting and discriminating individuals with mental illness may be a way in some communities to protect their own social prestige by not being associated with those who are seen deviant.

Further to this attribution of responsibility to internal factors as personal weakness and irresponsibility was also found to be prevalent in Rose et al.'s (2011) study. For example, a participant from Greece has mentioned being misunderstood and perceived as irresponsible by his father for not working due to his illness. As discussed earlier in this chapter attributing responsibility to personal character tends to increase blame thus results in more negative attitudes towards individuals with mental illness (See Section 2.6.3).

'Limited romantic relationship' was another emergent theme in this study. The same participant was also told that she was not good enough for the family's son due to her illness after her aunt tried to set them up. Although negative attitudes of the general public

were mostly prevalent throughout the interviews some positive experiences were also mentioned. For example, a participant from Greece noted that the neighbours were being nice and helpful towards him. Another participant from Cyprus also noted meeting some nice people who were accommodating. It could be argued that in countries, as Cyprus and Greece where collective culture is more dominant people are likely to help each other and show support. When it comes to mental illness, however, helping behaviour is diminished due to the fears of particularly symbolic threat. It may be argued that people of such cultures avoid being involved with individuals who have mental illness in order to protect their societal image. For this reason although there is sympathy within these cultures, stigma towards individuals with mental illness is more prevalent particularly within the close relationships which may lead to a marriage and genetic contamination; symbolic threat.

Bernice, Pescosolido, Tait, Jack and Long (2013) conducted another international study on the prejudice associated with mental health problems. In their study, Bernice et al. (2013) tried to address three questions addressing different aspects of stigma, identified by the previous research. The first question that they wanted to address was if there were bigger challenges faced by individuals with mental illness, their families and care workers as a result of culturally determined beliefs, attitudes and opinions on mental health problems. They then wanted to address the lack of knowledge and inclusion of individuals with mental illness and the impact of these on treatment of these conditions. Finally, they wanted to examine if the participants respond to schizophrenia and depressions similarly or differently. Sixteen countries were included and participants were represented either with depression or schizophrenia vignettes that were designed following the Diagnostic and

Statistical Manual of Mental Disorders (4th Edition) definitions. Participating countries were; Argentina (n = 1420); Bangladesh (n = 1501); Belgium (n = 1166); Bulgaria (n = 1121); Brazil (n = 1522); Cyprus (n = 804); Germany (n = 1255); Spain (n = 1206); Great Britain (n = 1030); Hungary (n = 1252); Iceland (n = 1033); South Korea (n = 1003); New Zealand (n = 1020); Philippines (n = 1200); United States (n = 1425); South Africa (n = 1550). They used pre-existing knowledge (16 items) and prejudice scales (27 items) in order to assess mental illness stigma. An exploratory analysis was conducted on both scales.

Regarding schizophrenia, approximately 69% of the sample from most of the countries could not give a correct name to the condition. This was, however, not the case for Cyprus and Bangladesh where more than half of the participants were able to provide the correct label for it. It was also found that compared to depression, schizophrenia was more commonly perceived as a brain disease which might suggest the persistent nature of the condition consequently resulting in higher levels of stigma. Results from Cyprus also revealed that stigma items; social rejection for schizophrenia, were endorsed more by the participants, compared to ones from other countries. For depression the most endorsed stigma items were in relation to responsibility; taking care of children and supervising others. These findings may suggest that perhaps the Greek Cypriot community do have a certain degree of knowledge about the possible symptoms of mental health problems as schizophrenia, they may lack factual knowledge about and familiarity with these conditions, consequently resulting in discrimination and stigmatization of people with mental illness. It may also be argued that higher levels of stigma found in social arenas can be attributed to the collective nature of the community. Stereotypes around irresponsibility,

threatening and dangerous nature of individuals with mental illness make them to be perceived as a deviant and un-trustworthy members of the more collective Greek speaking Cypriot community.

Moreover, some studies also showed the existence of negative attitudes within the mental health professionals who work in Cyprus. Panayiotopoulos, Pavlakis and Apostolou (2012) used the Attitudes towards Severe Mental Illness (ASMI) in order to assess negative attitudes particularly stereotypes and optimism of both professionals and general public in regards to integrating those with mental illness into the community. Results showed that the general public's attitudes were more positive and optimistic as opposed to the professionals. They also found that the general public held fewer stereotypes than the professionals. In either part of the island issues as mental health problems are generally dealt within the family. For this reason it could be argued that the professionals working in the field of mental health and illness generally come into contact with those who have mental illness at a very late stage when families are no longer able to care for their relatives. This might in turn worsen their perceptions about those with mental illness. In addition to this, mental health professionals in the island are educated using the medical model of illness, which as discussed earlier had been shown to worsen the attitudes towards those with these conditions. It could, therefore, be said that although they may have a greater exposure to such conditions, their educational background as well as experiences may have led them to perceive mental illness as a condition that is persistent and hard to treat consequently resulting in negative attitudes. This is particularly concerning as negative attitudes towards individuals with mental illness reduces empathy and compassion towards them which is a key for therapeutic alliance and recovery (Ross & Watling, 2017).

As well as showing the wide-scaled nature of mental illness stigma in the Greek Cypriot community, these studies also show the urgent need for more studies to be carried out within field. It is, however, not sufficient enough to focus on one community and therefore, attitudes of the wider Cypriot community including Turkish speaking ones need to be considered in order to effectively address stigma of mental illness throughout the island.

2.8 Conclusion

This chapter allowed researcher to consider and articulate factors that play a vital role on the maintenance of negative attitudes towards mental illness across the world as well as the Turkish and Greek speaking Cypriot communities of Cyprus.

Although mental health problems are widespread in the island, studies within the field of stigma are very limited for these communities. Previous literature suggests that approximately 20% of the population will experience a mental health problem across their life times (Kessler et al., 1993; Piccinelli & Wilkinson, 2000; Waraich et al., 2004). A very recent study carried out by Alexi, Moore and Argyrides (2017) with 196 Greek Cypriots living in Cyprus also showed that approximately 24% of the sample population in this study reported being diagnosed with a mental health problem within the past 12 months. This is in a confirmatory manner with the international literature suggesting similar rates in relation to the experiences of mental illness (Waraich et al., 2004). Unfortunately such information does not exist for the northern part of the island, however, in an interview with Havadis newspaper in 2016 Dr. Akbirgin (head of the mental health department of the national hospital located in the northern part of Nicosia), had noted that 18,540 people had

been treated for psychological disorders in 2015. Most of these individuals were reported as having addiction problems, psychosis and/or mood related issues as depression and anxiety. It should also be noted that numbers from either side of the island are likely to be under representative for the reasons discussed throughout this chapter such as being hesitant to disclose experiencing a mental health problem due to a fear of being stigmatized (Papadopoulos, 2009). Considering the widespread nature of mental health problems across the island and studies showing the existence of stigma towards mental illness within the GC community, it is necessary for further studies to be carried out to address the negative impact of stigma.

One of the main factors highlighted in this chapter as playing a vital role on attitudes towards and stigmatization of individuals with mental illness was culture. For this reason the next chapter of this thesis will be focusing on these communities and their complex history. Understanding the history of the island carries a great importance for this research as events experienced in the past contributes to the cultural and societal structures of the societies which impacts on attitudes towards mental illness.

Chapter 3- Historical Account of Cyprus

3.1 Introduction

As discussed in Chapter 2, much research that had been carried out adds to the researchers' understandings of mental illness stigma by identifying factors that may worsen or moderate stigmatizing attitudes towards mental illness. For example some of these previous studies noted that having had a previous experience and/or personal contact with people who have mental illness appear to be playing a positive role on the reduction of stigma (Papadopoulos, 2009; Penn, Kohlmaier & Corrigan, 2000). Moreover, while knowledge about symptoms of mental illness and perceived severity of mental health problems had been highlighted as factors that increase negative attitudes, knowledge in regards to the treatment options, of the recovery from mental illness, and being hopeful about the future had been found to reduce negative attitudes and stigmatization of those with mental health problems (Henderson, Evans-Lacko, and Thornicroft, 2013; Acharya & Agiues, 2017). At a higher level, a World Health Organization's International Study of Schizophrenia (ISoS DATE) indicated the impact of society's level of development on shaping attitudes towards mental illness (Martin, Lang & Olafsdottir, 2008). As Goffman noted, all these factors form one's perception around what is accepted. Stigma is, therefore, accepted as a social phenomenon that is rooted in social relationships, which consist of both

individual and contextual factors. Considering cultural and societal contexts' roles on creating a basis for marking difference and, therefore, stigmatization of people with mental illness, this chapter will discuss the historical, political, economical and societal factors of Turkish and Greek speaking Cypriot communities. This will be done in an effort to understand and better conceptualise the complex stigma construct that may exhibit in these communities.

According to Liu (2012), history and the shared knowledge influence one's cultural values and norms as well as the societal identity, which in turn affects one's belief structure and perceptions about others. For this reason, researcher believes that the complex history of Cyprus which impacted on the cultural norms, values and the societal identity of the two Cypriot communities - Turkish and Greek - will undoubtedly influence the way they perceive each other and the way they perceive those with mental health problems. Researcher also believes that the complex and traumatic history of Cyprus, as well as the very recent economic crisis experienced in the Greek speaking Cypriot community plays a role on attitudes towards mental illness. Furthermore, long lasting feelings of isolation in the North part of Cyprus where majority of the Turkish speaking Cypriots reside, affect the general mental health of individuals but also the way, which the society perceives, health conditions like mental illness. Due to this, researcher will start this chapter by examining the history of Cyprus including the long lasting ethnic-conflict between the Turkish and Greek speaking Cypriot societies that led to war and the division of the island into two ethnic zones. The negative consequences of the conflict, particularly the concept of "collective trauma" experienced by both of the communities, its transmission as well as the way this may relate to attitudes towards mental health problems, will also be discussed. The

chapter will end with the discussion of the way more recent developments in these communities might be contributing to the attitudes consequently stigmatization of mental illness in the two major ethnic communities of Cyprus. These recent developments are namely the European Union directives, policy and regulations with regards to mental health and the recent economic crisis in the southern part of Cyprus, and the isolation of the globally unrecognised northern part of the island, which is without a recent policy on mental health.

3.2 Brief History of the Island

Cyprus is the largest island in the eastern side of the Mediterranean Sea. It is one of the smallest EU countries with only Luxemburg and Malta being smaller in size. Greek settlers came to Cyprus approximately in 6000's B.C (Maric, 2009). The Ottoman Empire took over the administration of the island in 1571 A.D when the first Ottoman settlers arrived in Cyprus (Spilling and Spilling, 2009). In 1878 British Empire took control and Cyprus became a colony of Britain in 1925. The colonisation of the island lasted thirty-five years and Cyprus became an independent nation in 1960 (Protopsaltis, 2012).

In 1950s EOKA was established, by the Greek nationalists who desired Enosis, which referred to the idea of uniting the island with Greece (Faustmann, Hubert, Ker-Lindsay & James, 2008). While many Greek speaking Cypriots desired this at the time, Turkish speaking Cypriots started to desire Taksim, which meant the division of the island into two ethnic zones: Greek and Turkish (Faustmann, Hubert; Ker-Lindsay & James, 2008). This was the point, which lead to different identities to be developed other than "Cypriot". Greek speaking Cypriots under the leadership of Archbishop Makarios III

actively started to work and campaign for Enosis. They initially started to rebel against the British Empire and later clashed with the Turkish speaking Cypriots (Skvarka, 2004). In 1955, a state of emergency was declared by the British Empire, which resulted in the deportation of Archbishp Makarios from the island in 1956. These negative events had worsened the relationship between Greek and Turkish speaking Cypriots.

Following the Greek speaking Cypriot led gorilla war against the British; the leaders of Greece, Turkey, UK and the two Cypriot societies signed the Zurich-London Agreement in 1959 (Dimari & Varnava, 2011). According to this agreement Cyprus will be an independent state with three official languages; Greek, Turkish and English as well as an independent flag (Dimari & Varnava, 2011). The respective communities will elect a Greek Cypriot national president and a Turkish Cypriot national vice-president (Dimari & Varnava, 2011). Another important component in the Zurich-London agreement was that Great Britain, Greece and Turkey would act as guarantors of peace between the two communities in the newly formed independent country (Meier, 2001). Two military bases were also kept in the island by Britain after the independent constitution was established in 1960. Makarios was elected as the first president of Cyprus in 1960 (Macris, 1960). Some Cypriots were, however, disappointed with these changes as they felt that the Turkish speaking Cypriots were given disproportionate rights (Macris, 1960). To them, as well as sacrificing the idea of ENOSIS, these arrangements also meant that the Turkish speaking Cypriots who were not considered as being a part of the independence struggle during the British colonial era of the island, were going to have privileges at the expenses of the Greek speaking Cypriots (Macris, 1960).

From early days, the Republic of Cyprus faced inter as well as intra-communal conflicts, which has led to violence in some cases (Hadjipavlou, 2008). It should be noted that perhaps one of the most important moments in Cypriot history was during 1963-1964 when Turkish-speaking Cypriots withdraw from the government of the Republic, and created territories under their administration (Hadjipavlou, 2008). Greek speaking Cypriots did not welcome this at the time, as they felt that this was an effort to accomplish Taksim. Although partition was not official then, Greek-speaking Cypriots took over the governance of the Republic of Cyprus while Turkish-speaking Cypriots started to rule the territories that they had created on the island (Tonkul, 2015).

During this time Cyprus as an island was going through some major changes socio-economically as well as politically. With the involvement of the Greek armed forces in the island Greek-speaking Cypriots started to re-consider their goals (Morelli, 2015). President Makarios established a new policy in which he stated, "*What is feasible does not always coincide with what is desirable*" (Morelli, 2015). This meant the abundance of the long-standing ideology of ENOSIS by the majority of the Greek speaking Cypriots (Morelli, 2015). This was perceived to be a positive development for both of the communities, which had led to inter-communal talks under the control of United Nations between 1968 and 1974. While the negotiations were taking place tension started to grow between President Makarios and the Greek junta, the dictatorship, which was governing Greece at the time (Theophanous, 2014). Further to this, the newly elected Turkish Prime Minister Bülent Ecevit had taken a firmer approach towards both Greece and Cyprus. In July 13 1974, Denktaş and Clerides finally managed to agree on a draft of a detailed settlement (Theophanous, 2014).

These positive improvements were short lived as on the 15th of July 1974, Greek Junta declared a coup against the President Makarios who was replaced by a pro- ENOSIS 'president'. Following this Turkey invaded the island on July the 20th, 1974. Although the Greek junta did not stay in power for long, Turkey carried on with its invasion stating that they are on the island to protect the Turkish speaking Cypriot minority. The consequence of this was major; approximately 40% of the Greek speaking Cypriots were displaced from their homes and thousands either lost their lives or were taken as prisoners by the second phase of the invasion called "Atilla" (Hadjipavlou and Kanol, 2008). This led to an occupation of the 38% of the Republic of Cyprus, which was cleansed from 200,000 Greek-speaking Cypriots, who as a result became refugees in their own island (Hadjipavlou & Kanol, 2008). Turkish speaking Cypriots also fled to the areas that were occupied by Turkey. The occupation of the island by the Turkish armed forces still continues to this date. At present there are more Anatolian Turkish settlers in the northern part of the island, which is declared as the "Turkish Republic of Northern Cyprus" (Kyriakides, 2015) than Turkish speaking Cypriots.

Up until 2003 the checkpoints that allowed two societies to cross from one side to another were closed, which prevented the two societies to interact for almost 30 years after the invasion. Further to this the Republic of Cyprus became a member of the European Union in 2004 whilst a suspension of the occupied North of the Island was enforced. The troublesome history of the island had impacted on the general wellbeing of the Cypriot communities in general as well as their understandings of different health conditions as mental illness. It has been documented recently that the priority given to mental health problems are reduced following the conflict (Ventevogel, 2016). It could be argued that in

such conflict situations priority is given to the survival of the community members. In this sense mental illness and health problems may be seen as an extra burden on the community members, which may lead to negative attitudes to be further developed towards these conditions. In addition to this efforts spent to fight mental illness stigma such as designation and implementation of effective policies and regulations on mental illness can also be under-prioritised. The next section of this chapter will focus on how traumatic past experiences might be playing a role on shaping attitudes towards mental health and illness. This will then be followed with the more recent developments and their possible roles on attitudes towards mental illness.

3.3 Trauma and Its impact on attitudes towards mental illness

Throughout history Cyprus had faced forced occupations, colonization as well as mistreatment (Hajisoteriou, 2010). Up to this date Cyprus and its people had faced many conflicts, which consequently resulted in individual as well as collective trauma in the whole community (Zeka, 2015). As a psychological term trauma refers to the psychological breaking point of an individual who went through negative human experiences that are not ordinary (Kellerman, 2007). While individual trauma impacts on person's mind and body, collective trauma influences the whole society and its structure. Collective trauma has been defined by Erikson (1976, p. 233) as "*a blow to the basic tissues of social life that damages live bonds attaching people together and impairs the prevailing sense of communality."* In its simplest form collective trauma is defined as negative experiences that are considered to be traumatizing and are experienced by a certain group of people. Veerman (2001) noted that victimization of a group as a result of political, social, ethnic, religious, gender and cultural beliefs; values and positions could be seen as examples of collective trauma. It

applies to each and every society, cultural and socioeconomic group and could be due to a natural disaster or man-made (Kellerman, 2007; Apfel & Simon, 2000).

According to Kellerman (2007) formation and the development of a collective trauma is slow. Negative impact of collective trauma includes the prevention of support and societal bond that are particularly important and necessary for people who are going through stressful and traumatic life experiences (Bolina & Boltin, 1986; Kellerman, 2007). According to many researchers such as Rowland-Klein and Dunlop (1998) collective trauma could be passed through generations via narratives consequently impacting the new generations many years later. Considering the fact that trauma experiences impact on the well being of the communities as well as the members' perceptions of world in general, it could be argued that it will also have an impact on perceptions of mental health problems.

Conflict in Cyprus started in the late 1958 still continues to this date in the form of ethno-territorial conflict, which refers to a conflict in a form of ethnic segregation by separating the living areas of the ethnic groups (Newman, Gurion & Sheva, 2011). Currently in Cyprus there are ethnically homogenous spaces, which are unlikely to become mixed in near future that will help two communities to interact more easily and create a homogenous nation and ethnicities. Since the invasion of the island both Turkish and Greek speaking Cypriots have endured pervasive poverty, economic instability and violence, which is traumatising. It could, therefore, be argued that the survivors of the conflict in Cyprus as well as the next generations will continue to bear the scars of these traumatic experiences. Acts of warfare such as killing, torture, significant damage could be extremely stressful and upsetting for those who had experienced such events. These warfare acts have a significant impact on mental wellbeing and could lead to mental health problems being

experienced more often in such communities.

Numerous studies have been carried out examining the impact of conflict on mental wellbeing. For example, studies conducted by researchers as O'Reilly and Stevenson (2003) and Bunting, Ferry, Murphy, O'Neill and Bolton (2013) on Northern Irish participants showed that those who experienced conflict are more likely to have mental health problems later in their lives. In line with this traumatic life events are the second most commonly cited cause of mental illness accounting for 82.7% after the drug misuse (89.4%) (Ukpong & Abasiubong, 2010). Following trauma, individuals may start to perceive self as well as the world inaccurately: resulting in increased stigma particularly towards one's self (Lee, 2015). For example, one may have reduced self-esteem, increased shame, feelings of stigma and guilt as a result of a traumatic life event. As a result of a trauma individuals may also constantly look out for any threat unconsciously, which may in turn lead them to develop lack of trust and negative beliefs about the world in general (Matthews & Stolarski, 2015). It could also result in increased levels public stigma towards those with mental illness.

Although no statistical information can be found in regards to the impact of war on Cypriot communities' mental health and well-being, research with such data exist in the neighbouring countries where similar traumatic events had been experienced. For example research done in Palestine by the Gaza Community Mental Health Programme among children aged 10-19 years in 2005 showed the prevalence of mental health problems following conflict. The results of this study showed that 32.7% of the children suffered from PTSD and required professional help. In another study done in Gaza by Mousa (2003) also showed that 53% of the refuge children expressed aggressive behaviour, 39% of the

children reported to have been suffering from nightmares. Similarly in Afghanistan sufferings of the community for more than two decades had also been reported to be leading to higher levels of mental health problems being experienced. The first study to be conducted in the field was carried out by Cardozo, et al., (2004) with 799 individuals aged 15 years or older. Of these 799 participants 67.7% reported depressive symptoms, 72.2% reported PTSD and a significant relationship was also reported between mental health status and traumatic life events.

Further to these studies, which were done to assess stigma across the communities in conflict also noted the existence of higher levels of mental illness stigma within these communities. For example Vantevogel (2016) carried out a study in Afghanistan and Burundi regions to explore the health system in such conflict regions. In this study psychosocial and mental health problems related to war were also explored. Focus-group interviews with 114 participants from the five different regions of Burindi had showed the existence of negative attitudes towards individuals with mental health problems. For example it was documented that people with a condition called Akabonge (Depression) are seen as unproductive members of the society and as those who are unable to help others or work. Thoughts around these individuals being out of their minds (Ugupayuka) and unable to function normally had also been noted by the participants in this study. It could, therefore, be suggested that the past negative experiences of the Cypriot communities might be playing a negative role on the community members' mental wellbeing as well as their attitudes towards mental illness.

In relation to attitudes towards mental illness, there might be a negative shift, particularly due to the fact that in war situations the main aim of the community members is

to survive and protect their community. Traditional stereotypes held about mental illness and people with such conditions as having a weak personality (Livngstone & Boyd, 2011), being dangerous (Mosaku, 2017), unpredictable and threatening (Murman et al., 2014) could, therefore, be particularly more effective on the development of negative attitudes towards individuals with mental illness in communities who went through traumatic experiences as Cyprus. Thus it could be argued that in communities in which conflict and trauma is being experienced, individuals who have mental health problems could be stigmatized and discriminated to a greater extent (Bein, 2011).

Although no studies had been carried out specifically with the members of the public from the conflict regions in regards to their perceptions of mental illness after traumatising events, there are studies that looked into the of mental illness perceptions of individuals returning from the conflict zones. For example, a study carried out by Iversen et al. (2011) aimed to assess stigma, which military personnel faced due to experiencing mental health problems. They interviewed 821 UK military personnel who took part in the Iraq war. Results of this study showed that 73% of the participants noted that they would not be seen as an asset to their unit members due to having a mental illness while 41% noted that those around them would perceive them as weak. This is unlike having a physical illness; in an event of war those with physical illnesses are perceived as heroes and as those who fought for the benefit of the community. Unlike physical illness, mental illness cannot be overtly observed thus while those who have physical disabilities tend to receive more sympathy, compassion and support, those with mental health problems tend to be seen as burdens on the community members and generally blamed for their conditions consequently resulting in higher levels of negative attitudes and stigma (Moore, 2013).

Both of the Turkish and Greek speaking communities had been in situations where each of the communities' objectives were to survive by sticking together, being self-sufficient and relying on their in-group members. In such situations those with mental health problems might have been perceived as weak, incapable and untrustworthy amongst the community members, consequently resulting in higher levels of stigma and discrimination. Further to this, it could be argued that as a result of trauma the idea of community members needing to stick together and rely on each other may have been strengthened thus negative stereotypes about individuals with mental illness had also been transferred to new generations that may have created a vicious cycle of public stigma.

Recent research also suggests that both adult and child mental health and community members' perceptions on these issues are linked not only to the experiences of past but also to the present events which result in inequalities (Miller, Omidian, Rasmussen, Yaqubi, & Daudzi, 2008; Panter-Brick, Eggerman, Mojadidi, & McDade, 2008). The next section of this chapter will, therefore, focus on the more recent developments, which may play a part on the experiences and perceptions of mental illness consequently mental illness stigma.

3.4 Increased Identification of Turkish and Greek speaking Cypriots with Turkey and Greece respectively

It should be noted that, as a result of collective trauma, commonalities are lessened amongst the community and so new communities might emerge which leads to a reduction of support given to individuals with mental illness (Veerman, 2001). Many aspects of the societal life are also influenced by the negative traumatic past events including communal

beliefs and values, environment and world-view of the people living in that society. This could be clearly observed in Cyprus as well. Prior to the inter-communal conflict both Turkish and Greek speaking Cypriots lived together in harmony under one government. Conflict has led these two communities to separate into two societies widening their different ethnic identities (See table 3.4.1). To aid a better understanding into the recent ethnic structure of the island the most recent census of the Republic of Cyprus is given in the table below. Unfortunately such official information could not be obtained for the occupied Northern part of the island where most of the Turkish Cypriots as well as Northern Cypriots of Turkish, Maronites, Armenians, Jewish descended individuals live.

Table 3.4.1

*Demographic Information of the Republic of Cyprus (Adapted from The Statistical Services, Republic of Cyprus Government, 2016)**

Population	Total=947,000
	Greek Cypriots= 706,800 (74.6%)
	Turkish Cypriots=92,200 (9.8%)
	Foreign Residents= 148,000 (15.6%)
Median Age	**Total: 36.4**
	Male: 35.1
	Female: 38
The religious groups which belong to the Greek Cypriot community constituted:	Armenians: 0,4% of the Greek Cypriot community
	Maronites: 0,7% of the Greek Cypriot community
	Latins: 0,1% of the Greek Cypriot community

Religion	Orthodox Christian 89.1%, Roman Catholic 2.9%, Protestant/Anglican 2%, Muslim 1.8%, Buddhist 1%, Other (includes Maronite, Armenian Church, Hindu): 1.4% Unknown 1.1%, None/Atheist 0.6%

**Note: data represent only the governmental controlled area of Cyprus (2016)*

With the increase in immigrant numbers especially from Turkey to the northern side of the island after the invasion, the cultural structure had also been influenced contributing to the increased differences amongst the Turkish and Greek speaking Cypriots. Although the absolute number is not known, it has been noted that at present there are more Turkish settlers living in the Northern side of the island than the actual Turkish Cypriots (Hatay, 2007). Currently it is believed that there are approximately 350,000 people living in the northern part of the island and approximately 120,000 of these people are believed to be Turkish speaking Cypriots. The majority of the remaining number of people is believed to be Turkish descended individuals who immigrated to the island after 1974 (Münir, 2011).

As a result of this ethnic change a new Turkish identity started to emerge particularly within the Turkish-speaking members of the Cypriot community. According to Marcus (2015) personal growth, following trauma can be achieved through social support and having a strong group identity while also hindering the symptoms of a post-traumatic stress. Tajfel's (1974) most influential work on Social Identity Theory suggests that self-concept is formed through one's membership of a group. Through this group membership individual is able to understand societal norms, values, practices and beliefs, which he/she

may turn to in the times of trauma and confusion. In support to Tajfel's theory, Ryan and Deci's (2000) Self Determination Theory also suggests that in order for one to feel a sense of security in regards to their relationships and identity, and achieve personal growth one must internalize the group's values via strengthening their connection with that particular group. Following this it is the researcher's belief that the identification of Turkish speaking and Greek speaking Cypriots with the Turkish and Greek identities respectively has increased particularly during ethnic clashes and after the Turkish invasion of the island, . Maintaining a supportive social network has been noted to be one of the strategies that help initiate resilience after a traumatic experience (Bradley et al., 2013). For example to this date it is a common saying amongst the Turkish speaking Cypriots that Turkey is their saver and, therefore, is hero of the Turkish speaking Cypriot nation. Turkey is generally referred as the 'motherland', and is believed to be supporting and protecting Turkish-speaking Cypriots.

In the case of Greek speaking Cypriot community, Greek Cypriot identity is expressed mainly in churches and monasteries (Balderstone, 2007). The Greek Orthodox Church, therefore, plays a significant role in the life and culture of the Greek-speaking Cypriots as they continue to celebrate the religious festivals and days of the saints. It should be noted that although there is an influence of Greece on the Greek speaking Cypriot community's culture and societal structure, they have managed to protect their Cypriot identity as well.

Turkish speaking Cypriots of today are, however, more concerned about the loss of Cypriot cultural identity due to being under occupation of the Turkish army as well as not having the necessary resources to record family histories, costumes, folk songs as well as

their unique dances (Balderstone, 2007). There is a bigger change in regards to demographic, economic, political, religious, social and cultural aspects in the north compared to the south side of the island (Hatay, 2007). There is an obvious effort being spent by the Turkish government for Turkification and Islamization of north Cyprus. As well as the rapid demographic change due to citizenships being granted to Turkish nationals on a weekly basis, there are many hotels and casinos being built in the north side that are under the control of Turkey (Aygin, 2017). More and more mosques are being built and the first Islamic school for children aged seven and 18 years was also opened in 2016 that was funded by Turkey. The second one is currently being build which will also be funded by Turkey in an effort to make not very religious Turkish speaking Cypriot community more religious; particularly Islamist (Aygin, 2017). Further to this, due to curriculum in the northern part of the island being in harmony with Turkey, Turkish history, geography and Islam religion is being taught in schools from grade one which undoubtedly plays a role on Turkish speaking Cypriots losing their Cypriot identity and gaining more of a Turkish identity since 1974 (Aygin, 2017). It could, therefore, be argued that the increased identification with the Turkish customs as well as traditions, due to Turkey's impact on North Cyprus's economy, politics, education and societal structure, had further increased the already existing differences between the Greek and Turkish speaking Cypriots. Researcher, therefore, believes that these widened differences particularly in regards to identity and culture as well as the societal structure will also play a role on the differing levels of stigma associated with mental health problems in the Turkish and Greek speaking Cypriot communities of Cyprus.

As highlighted in Chapter 2 studies that were carried out with the Turkish and Greek communities showed the existence of stigma towards mental illness. Due to Turkish and Greek speaking Cypriots' identification with Turkey and Greece respectively, it is expected that the similar stereotypical beliefs to exist in the two Turkish and Greek speaking Cypriot communities of Cyprus. This is because such stereotypes are culturally constructed and maintained partly through media (See Chapter 2) (Pescosolido, Martin, Lang & Olafsdottir, 2008).

Considering the fact that the Turkish and Greek speaking Cypriot communities of the island are following Greek and Turkish media regularly, similar types of stereotypes and prejudicial beliefs about mental illness are also expected to be found in these communities. Parallel to this, the findings of the studies carried out by Greek speaking Cypriot, Greek (Papadopoulos, 2009) and Turkish (Çam, 2011) participants particularly showed that these societies are classified as being collective and in such cultures mental health problems are understood as a threat to societal order and individuals with mental health problems are viewed as dangerous and unpredictable. More emphasis is, therefore, put on controlling and separating individuals with mental illness within these communities, which results in stigma (Ozmen et al., 2004; Papadopoulos, 2009, Gur & Kucuk, 2016).

Assuming the attitudes of the Greek and Turkish speaking Cypriots will be the same, as Greek and Turkish participants due to cultural and ethnic similarities will, however, be oversimplifying the complex nature of mental illness stigma. After all each of these communities have their own societal and political structures. Investigation of the recent developments in both of the Cypriot communities is, therefore, needed. For this

reason the next section of this chapter will focus on the most recent events that are believed to play a role on attitudes towards mental illness; gaining a membership of the European Union, Isolation of the northern part of the island, and the economic crisis experienced in 2013 by the Greek speaking Cypriot community.

3.5 Recent Developments that took place in either side of the island

On the 1st of May 2004 Cyprus joined the EU as a whole country, however, it is noted as the only divided country to remain in Europe (Passass & Katakalou, 2012). Even though Turkish-speaking Cypriots are not under the administration of the Republic of Cyprus government, they are considered as members of the Republic of Cyprus and thus also are members of the EU (Hatay, 2014). During the same period of Cyprus becoming a EU state, a plan known as the "Annan Plan" was proposed by the United Nations as another attempt to resolve the Cyprus conflict (Morelli, 2015). Briefly, the Annan Plan aimed to restructure Cyprus as a "United Republic of Cyprus". According to this proposal there would be only one federation, which will consist of two states (Morelli, 2015). It was revised many times prior to being given to both Turkish and Greek speaking Cypriots on a referendum. The result of the referendum was disappointing particularly for the 65% of the Turkish speaking Cypriots who supported the plan. The majority of the Greek Cypriots rejected it with only 24% of them supporting the plan, as it did not contain adequate assurances that all the citizens could safely return to their homes (Muscat, 2008). It is important to note that at the time of the invasion the ratio between Turks and Greeks was 20:80 and whilst 200,000 Greek-speaking Cypriots were displaced only 45,000 Turkish-speaking Cypriots were displaced (Aylin. 2014). Therefore the matter of land and

individual properties is very complicated and has remained the main obstacle to a just and fair solution to this date (Aylin, 2014).

Although increasing efforts are being spent in regards to the re-unification of the island since the openings of the first checkpoint in 2003, developments in the field of mental health and wellbeing as well as the efforts spent in either side of the island are different. This is because each society has its own societal structure, health system, policies and resources. These differences in particular are believed to be affecting the attitudes of Turkish and Greek speaking Cypriots towards mental health issues as well as leading to different levels of mental illness stigma being expressed in the two societies.

Perhaps one of the factors that had a major impact on the development of psychology as a field in the southern part of the island was gaining of the EU membership. In preparation for entry to EU the Republic of Cyprus was required to revise and change numerous policies and legislation in order to meet the entry criteria. This meant that mental health policies and regulations had to be revised. This revision particularly aimed to integrate individuals with mental health problems into their communities via de-institutionalisation and adopting a community based treatment approach of mental illness (Georgiades, 2009). On the other hand, the globally un-recognised northern side retained its out-dated policies and regulations (originated in 1931). Whilst the revised policies in the southern side of the island had brought about many positive changes to the care and treatment of mental health and individuals with mental illness, the northern side of the island continues to endure the embargos voted by the United Nations as a result of Turkey's invasion and illegal occupation of that part of the island, which resulted in economic and

political growth reduction. In particular to mental health, the northern part of the island is still with an out-dated policy that was established in 1931.

Although positive changes had been happening in the south very recently in 2013 Greek-speaking Cypriots were hit by an economic crisis (Levush, 2013). Previous research noted the impact of an economic crisis and the determinant power of it on mental well being (Waddell & Burton, 2009). Waddell and Burton (2009) also noted that economic crisis threatens mental health as the protective factors decrease while the risk factors increase after experiencing such crisis. They also suggested the benefit of employment on mental health where factors such as job security, sense of increased control, social support available at work are considered to be the protective factors for maintaining a good mental health (Sanderson & Andrews, 2006).

In contrast, factors such as poverty, financial problems and social deprivation are considered to be the risk factors for protecting and maintaining good mental health (Laaksonen 2013). As well as influencing mental well being, economic crisis plays a great role on the priority given to mental illness in communities. Although there is no National Health System in Cyprus, the government has been shown to be effective in providing welfare benefits to those in need and to their caregivers (Amitsis, 2012). This was also documented in a brief report produced by Christofides (2011) on an unemployment insurance and social welfare. With the economic crisis, however, government of the Republic of Cyprus had been asked to implement cuts on the welfare benefits. Individuals with mental illness as well as their care givers were greatly affected by this because this group is also included in these implemented austerity measures. This meant that their benefits were reduced and they were also being asked to pay for some of the medical and

psychiatric treatments, which they needed (Panayiotopoulos, Pavlakis & Apostolou, 2013). This meant that the early treatment of mental illness, which helps control symptoms allowing individuals to carry on with their daily lives, might not be sought on time. This delay possibly results in individuals' life opportunities being limited particularly in employment. In addition to this treatment avoidance will also result in secrecy consequently reducing public's awareness of and contact with individuals who have mental illness. Moreover, those who avoid treatment tend to seek help when symptoms are no longer manageable. As discussed in Chapter 2 such factors may result in community members to have more of a pessimistic outlook on prognosis of mental health problems, which may again lead to an increase in negative attitudes, and stigma of mental illness.

In support to this, a study that was carried out by Evans-Lacko, et al. (2013) showed the negative impact of economic recession particularly on individuals with mental health problems. According to them, at such times individuals with mental health problems could be at a greater risk of losing their jobs, as there is an increase in competition. For their study, they collected data from the Eurobarometer surveys (of 2006-2010) around 27 EU countries, which were analysed in regards to the changes in unemployment rates of individuals with and without mental health problems. Results showed that after the recession in countries as United Kingdom (2008), Spain (2008) there was a significant gap in unemployment rates between individuals with and without mental illness; those with mental health problems having significantly higher unemployment rates compared to those without such conditions. These findings were supported by other researchers who also reported the link between economic crisis and increase in discriminative and stigmatizing

attitudes towards mental illness (Bouras & Lykouras, 2014; Wahlbeck & McDaid, 2012; Shrivastava, Johnson & Bureau, 2012; McDaid, 2015).

Further to these, in the northern part of the island, factors such as the failure to find a solution for the re-unification of Cyprus, the continuing isolation felt by the Turkish speaking Cypriots, an increase in unemployment, inequalities, ethnic and societal changes overtime since 1974 have significantly contributed to the deterioration of their general mental health, as well as their attitudes towards mental illness. Mental illness is still considered to be a taboo subject; therefore, it is not publicly discussed making general public less aware and familiar with such conditions. Due to this, many individuals may remain undiagnosed and untreated for a long period of time or not receive treatment at all.

As well as economical inequalities, lack of policies and regulations in regards to mental health and illness in the northern side of the island could also be seen as an evidence that shows the lack of priority given to this topic, by those in power. So long as policy remains unchanged the tabooed and stigmatizing nature of mental illness will prevail (Corrigan, 2004). For the reasons outlined in this chapter researcher believes that the existence of negative attitudes towards mental illness, therefore, stigma in either of the communities. She also thinks that compared to the Greek speaking Cypriot society, higher levels of stigma will be evident in the Turkish Cypriot society.

3.6 Reflexive Account-I

Walsh (2003) had defined reflexivity as being both personal and interpersonal. Personal reflexivity refers to the ability of researchers to be aware of their own biases, beliefs and assumptions and their role in research. Inter-personal reflexivity, on the other

hand, refers to researcher-participant interactions that may also influence the whole research process. One of the core elements of a rigorous research is reflexivity. As this chapter looked at the history of Cyprus this section of this chapter will, include both personal and interpersonal reflexive accounts provided by the researcher herself.

I am a Turkish speaking Cypriot who also has a high level of direct contact with many of the Greek speaking Cypriots. I, therefore, have a personal experience with each of the cultures studied in this thesis. I come from a house where Greek language was spoken amongst the older generation and have family who can be defined as being liberal, so interactions between the two communities, who have a troubled history, was always encouraged from my childhood. I believe this encouragement, which I received particularly from my parents, had made me decide to study stigma of mental illness with not just my own community but also with the Greek speaking Cypriots.

The one difficulty I faced at the very beginning of my PhD study was that I found myself in a position to choose an appropriate name that will allow the reader to make distinctions between the two communities, which I never did before. This was very difficult to do as I had always perceived myself as a Cypriot and never felt the need to define myself as being Turkish prior to this project. It made me start questioning the two communities' structures, beliefs, norms and values, which I intuitively always deemed to be very similar. At that point I knew that I needed to keep an open-mind and move away from the assumptions, which I had, by ensuring objective outlook into the two communities. At the time of starting my PhD I had been living in the UK for the past six years and I believe living abroad allowed me to approach the research process more objectively. I had also started to read more on the history of the island, which also made me, gain new knowledge

about the uniqueness of each community. On top of that my educational background in psychology made me realise the fact that I needed to increase my self-awareness activities, which marked the starting point of my reflexive journey. In order to increase my self-awareness I had decided to attend seminars dedicated for people who wish to learn about themselves through interactions with others and feedback activities. I believe my educational background as well as the further training I received enhanced my ability to self- reflect consequently increasing my self-awareness. Using the new knowledge and techniques I had learnt I decided to define the two communities not as Turkish or Greek but instead refer to them as Turkish speaking and Greek speaking Cypriots. To the researcher this definition acknowledges the Cypriot roots of the two communities who differ mainly in language, religion and ethnic origin.

3.7 Conclusion

This chapter had highlighted the complex history, long-lasting and unresolved conflict, and recent negative events experienced by the Cypriot people. These experiences inevitably impacted on culture, societal structure, economy and politics. More importantly historical and more recent events in Cyprus are believed to have led to the collective sense of fear, insecurity, guilt, and stigmatization of people with mental health problems. Many years have passed since the conflict; however, neither Turkish nor Greek speaking Cypriots forgot what has happened to them particularly between 1960 and 1974 (Broome, 2005). Turkish speaking Cypriots put emphasis on the fact that they were treated as second-class citizens in their own country and feared for their safety between 1963-1974 periods. Greek speaking Cypriots, on the other hand, put emphasis on their losses both materialistic and physical as a result of the Turkish invasion and their inability to return to their homes. One

certain fact is that the conflict has divided the island of Cyprus into two regions that are ethnically different. No contact was made between the two regions until 2003. Cypriots in both of the regions were, therefore, left with painful memories and traumatic past experiences, which remain unresolved and are still being passed through the generations more than 40 years later. For example, as a result of the 1974 conflict, the fate of 1508 Greek-speaking Cypriots and 493 Turkish-speaking Cypriots who are still missing remains unknown. In addition to these, many families lost mainly young men who were killed in combat, almost 50% of the population lost their homes, many of whom had no option but to leave Cyprus also leaving behind a grieving family and friends who are often unable to cope with the overwhelming changes in their lives.

Further to these, the recent negative events such as prevalent feelings of isolation from world and on-going economical dependency to Turkey of Northern Cyprus has left many Turkish speaking Cypriots feeling as prisoners in their own country and unhopeful of the future. A recent economic crisis experienced in the Southern Cyprus also increased the inequalities within the Greek speaking Cypriot community members disadvantaging particularly those who have mental illness, as well as leaving the community with painful memories once more. Researcher believes that the recent negative events along with the complex and traumatic history of the island had resulted in widened differences amongst the two communities in relation to their mental wellbeing as well as each communities' perceptions of mental illness. As well as the past events, recent ones had also resulted in less priority to be given to mental health and wellbeing. In order to help individuals with mental illness to improve their quality of lives, it is, therefore, necessary to carry out studies that will help address stigma of mental illness in Cyprus. The next chapter of this thesis

will, therefore, outline the methodological approach, which was adopted in an effort to assess mental illness stigma in the Turkish and Greek speaking Cypriot communities of Cyprus. Researcher will further discuss the rationale in adopting a mixed method approach for this thesis, which is believed to be the most appropriate strategy in answering the research questions that are also stated in the next chapter.

Chapter 4-Methodology

4.1 Introduction

In Chapters 1 & 2 a number of qualitative and quantitative studies have been mentioned that highlighted the existence of public stigma towards those with mental health problems around the world (Corrigan & Watson, 2002, Stier & Hinshaw, 2007; Link, Watson, Wardinski & Garcia 2004; Corrigan, Watson, Wardinski & Garcia, 2014; Mestdagh & Hansen, 2014). Although stigma towards mental illness had been reported globally, findings of the previous research are not consistent across communities showing the varying nature of mental health related stigma (Hampton & Sharp, 2014; Ciftci, Jones & Corrigan 2013; Papadopoulos, Caldwell & Foster, 2013; Li, Li, Huang & Thornichroft, 2014; Elkington, Hackler, McKinnon, Borges, Wright & Wainberg, 2011). Whilst these studies help researchers and practitioners to be better able to conceptualise stigma more community specific studies are needed. This will enable researchers to better understand the potential reasons that underlie mental illness stigma and find ways to diminish it effectively, consequently reducing the level of public stigma in different communities.

As stated in Chapter 1 this study aimed to investigate mental illness stigma in Turkish and Greek speaking Cypriot communities by assessing public's attitudes using a cross-sectional design. Researcher also wanted to assess the relationship between public stigma and the factors that have been identified by previous research as relating to it, notably: knowledge, familiarity and culture. For this purpose, a correlational design was used. In line with the objectives of this research public stigma will be conceptualised using Corrigan's (2000) definition outlined in Chapter 2. For the quantitative part of the project, the researcher generated hypotheses based on the previous literature in the field (See Table 4.1.1) (Boer, Mula & Sander, 2008; Escobar & Debberma, 2015; Corrigan, 2016; Ku & Ha, 2015; Angermayer, et al., 2015).

Table 4.1.1

Research Hypotheses for the Quantitative Study

1. Negative attitudes that lead to stigma exists in Cyprus; both in the communities of Greek and Turkish speaking Cypriots.
2. Stigma levels are correlated with the three most identified factors by the previous researchers; knowledge, familiarity and culture.
    - 2a. Higher levels of knowledge about mental illness lead to lower levels of stigma towards mental illness.
    - 2b. Higher levels of familiarity lead to lower levels of stigma towards mental illness.
    - 2c. Collectivist cultural orientation leads to higher levels of mental illness stigma.
3. Turkish and Greek Cypriots differ in their cultural structures.
    - 3a. Turkish Cypriots are more collectivist.
    - 3b. Greek Cypriots are more individualist.
4. Turkish Cypriots will have less factual knowledge about mental illness compared to the Greek Cypriots.
5. Turkish Cypriots will have less familiarity with mental health problems compared to the Greek Cypriots.
6. Turkish Cypriots will have higher levels of mental illness stigma compared to the Greek Cypriots.

The aim of this chapter is to explore the philosophical foundation and techniques used in this study. Additionally, it also looks at the scientific concepts and theories that justify the use of a mixed method approach. In this chapter, there will also be a detailed description of the study's design, sampling techniques, data collection strategies, ethical considerations, tools that are used, and the rationale for using them.

4.2 Defining "Paradigm"

The aim of every researcher is to seek answers to the questions, which they propose when carrying out research. In the field of mental illness stigma, researchers'

understandings of what attitudes, stigma and mental illness are influence the paradigm that they choose. It is, therefore, important at this stage to define what is meant by a paradigm and how this is linked with the current research project. This is considered essential in the context of the adoption of a mixed-methods approach.

The term 'Paradigm' was introduced by Kuhn (1962, 1970) and has been given several definitions in the literature; world-view, epistemological standpoint, agreed perceptions amongst group of researchers and a research model. Although Kuhn (1970) mainly saw paradigm as the agreed beliefs amongst groups of researchers, in social science methodology debates, it is commonly referred as an epistemological stance (Cothren, et al., 2007). Other influential people in the field have, however, defined paradigm as *"a worldview, together with the various philosophical assumptions associated with that point of view."* (Teddlie & Tashakkori, 2009, p.84). Similar to this, researchers as Creswell and Plano Clark (2007) suggested that the positions adopted on each of the elements make up the worldview (Creswell & Plano Clark, 2007), in other words elements that make up varying ontology, epistemology, axiology and methodology (Teddlie & Tashakkori, 2009). Creswell and Plano Clark (2007) have generated four worldviews via the use of these concepts; Post-positivism, Constructivism, Transformative and Pragmatism (Hall, 2013).

4.3 Positivist and Interpretivist Paradigms Explained in Detail

Social scientists desire to explore dynamic and complex issues that could range from historical analysis of what has happened in the early years of the human race to the detailed analysis of what is happening at present. In an effort to understand and examine these varied and complex social phenomena, they use different research paradigms. Although many of these paradigms have been identified by different researchers; as Neufeld, Harrison, Hughes, Spitzer and Stewart, (2001) and Mackenzie and Knipe (2006), according to Sinha and Kumar (2005) there are two main ones that create the ground of social science research. These are the positivist approach, which is mainly related to the quantitative methodology, and the interpretivist approach that is mainly linked with the qualitative one.

During the 20th century, the quantitative approach was the predominantly used research method by social scientists (Tedlie & Tashakkoro, 2009). The method was generated from natural sciences such as Biology and Chemistry and aims to examine concepts that are observable and somehow measurable such as levels of stigma towards mental health problems (Tedlie & Tashakkoro, 2009). Others can then objectively repeat these observations and measurements. Over the last few decades, however, this ideology of observing and measuring concepts had stopped satisfying some of the social scientists who started to look for other means of carrying out research and understanding reality (Babbie, 2015). Unlike those who perceive themselves as quantitative researchers, they stated that the aim should not be to measure and observe the concept, but to understand what the experience means for the unique individual (Cohen, Manion & Morrison, 2013). This has subsequently pushed researchers to look for other ways of carrying out research in the field of social sciences. This later led to the development of qualitative methodology that aims to

understand the reason behind the way society functions and the way people act (Cohen, Manion & Morrison, 2013). Emergence of a new methodology led some of the researchers to prefer one technique over another; quantitative purists and qualitative purists (Tuli, 2011). Those who are quantitative purists argue that the reality is objective and social observations should be seen as units. The qualitative purists, in other words interpretivists, on the other hand, disagree with the positivist approach and argue that reality is a subjective concept that is construed socially by individuals (Krauss, 2005).

4.4 Justification for using a Mixed-Methods Approach

Researchers, such as Pescosolido and Martin (2015), noted that stigma in relation to mental illness is a complex concept to be studied. This is because, it is related to many different factors such as labelling, unfavourable stereotypes, limited knowledge and familiarity with mental health problems (Kramer et al., 2005). Stigma could be visible or invisible and can persist across different systems as families and communities. It can result in differing feelings and behaviours towards people with mental illness, such as anger, fear, and, prejudice, as well as discrimination of such individuals with mental health problems (Kramer et al., 2005).

Although paradigms such as positivism and interperetivism enable researchers to gain a perspective on a concept that is being investigated, adopting only one approach limits the researchers' abilities to obtain a holistic understanding of the complex concepts such as the publics' perceptions on mental health problems and the consequent stigma. Even though it is possible to gain an understanding about how people may be perceiving individuals with mental health problems and what the scale of stigma is towards such issues

with a use of quantitative approaches, without approaching individuals from different communities and allowing them to express their thoughts and ideas in regards to mental health problems, researcher believes that it is not possible to gain a comprehensive picture about the concept of stigma. This is because according to Denzin, Lincoln and Giardina (2006) while qualitative approaches advocate that the reality is socially constructed and it strives to understand how these meanings are created, quantitative approaches focus on the difference amongst the groups and correlations between certain variables (Denzin, Lincoln & Giardina, 2006).

Furthermore, there are certain difficulties in this research that will be better addressed using both quantitative and qualitative approaches. Firstly no previous research had been conducted in Cyprus with both Turkish and Greek speaking Cypriot communities, therefore, much is unknown about the existence and the nature of the attitudes towards mental illness and mental health related stigma in Cyprus. Secondly, no previous research exists on how stigma of mental illness may manifests in the two ethnic communities and constructs that relate to it. Finally, another difficulty that the researcher faces in this project is that, as mentioned in Chapter 3 the two main communities of the island share a troublesome history that is traumatic and very complex, including the 1974 war which resulted in isolation from the world of Turkish speaking Cypriots and the more recent and war related economic crisis in Greek speaking Cypriot community of the island. In researcher's opinion all these factors contribute to the development of stigma towards mental health problems and those with such conditions in both societies. This is because these factors influence peoples' perceptions of what mental illness is in general and consequently their attitudes towards those with mental illness. It will, therefore, be very

difficult to gain a holistic understanding about stigma towards mental illness in both societies if only one paradigm is adopted.

4.5 Emergence of Mixed Methods Research as a New Era and Pragmatism Explained

According to Teddlie and Tashakkori (2009), mixed method research is considered to be the third type of methodology after the traditional quantitative and qualitative approaches. Similarly, Creswell (2005) also noted that there are now three acknowledged methods that researchers can adopt when carrying out research. These are quantitative, qualitative and mixed methods. The use of two different approaches allows researchers to gather a more complete understanding about the proposed research problem. Researchers such as, Famini, Penski and Wilson (1992), McKinley and Trefftz (1993), and Baum (1995) noted that quantitative and qualitative approaches should be seen as complementing each other rather than competing methods. The decision, which researchers make in regards to mixing these two approaches should be centred to the research problem identified and research questions, which the researchers desire to answer. Arnault and Fetters (2012) also noted that mixed methods have made it possible for researchers to investigate complicated health-related concepts such as stigma towards mental health problems.

According to Denscombe (2008), during the last decade with the contributions of writers as Creswell (2005); Tasakkari, Johnson, Onwuegbuzie (2007); Greene, Teddlie and Morgan (2010) mixed methods approach was developed and recognized as the third major research paradigm. It is, however, distinguished from quantitative and qualitative paradigms on the basis of its ability to combine distinct concepts and theories.

Mixed methods approach started to emerge during the 20th century with the work of sociologists and cultural anthropologists (Creswell, 1999). Chronologically it could be argued that it has been formed from 1990s onwards after the common use of positivist approach associated with the quantitative method from 1950s to 1970s and the dominant use of interpretivist approach associated with the qualitative methods during mid-1970s to 1990s. According to Johnson Onwuegbuzie, and Turner, (2007) researchers are now in an era where three different methodological paradigms exist; quantitative, qualitative and mixed methods.

After the pioneering work of Campbell and Fiske in 1959 on mixing methods, other researchers such as Webb, Campbell, Schwartz, and Sechrest (1966) and Denzin (1978) started to carry out projects about the triangulation of different research methods. Further to these, acknowledgement was also made to Cook and Reichard (1979) who also carried out a seminal work showing the possibility to use both quantitative and qualitative methods in one research project. According to Tashakkori and Teddlie (2003) work carried out by the aforementioned researchers, mixed methods approach has earned popularity amongst the social scientists. It consequently evolved as a different methodological concept with its own distinct view about the world and the procedures adopted (Tashakkori & Teddlie, 2003).

The distinct nature of the Mixed Methods approach, its main ideas, and procedures can be clearly seen in the work of many researchers such as, Creswell (2003), Creswell and Plano Clark (2007) and Tashakkori and Teddlie (1998, 2003). The defining characteristics of the Mixed Methods approach are represented in Table 4.5.1

Table 4.5.1

The Defining Characteristics of the Mixed Methods Approach Introduced by Tashakkori and Teddlie (1998)

1. The use of both quantitative and qualitative approaches in the same research project.
2. Clarification of the sequencing and priority given to Quantitative and Qualitative approaches in the project with the research design.
3. Detailed explanations in regards to how quantitative and qualitative elements relate to each other.
4. Explaining the use of pragmatism as the philosophical basis for mixed methods research.

4.6 Advantages and Disadvantages of Mixed Methods Research

Due to it being a fairly new paradigm there are some variations of the ideas in regards to why mixed methods should be used by researchers (Tashakkori & Creswell, 2007). Recognition and acknowledgement of these variations are fundamental for those who aim to use mixed methods approach in their research projects. In his extensive review of the previous literature on social research Brynen (2006) highlighted some variations, which were parallel with what Collins, Onwuegbuzie and Sutton, (2006) have also noted. According to them, these include enhancing the accuracy of the results by combining the

data obtained via the use of qualitative and quantitative approaches. Combining two different kinds of data in order to obtain a more complete picture about the phenomena being studied. Also avoiding any bias and minimizing the disadvantages, which may be caused by adopting only a single approach. Furthermore, mixed methods can be used as a way to help researchers with the sampling procedure. For example, using questionnaires with a large sample in order to recruit possible participants for interviews.

Similarly, according to Johnson and Onwuegbuzie (2004), rational and practical solutions to paradigmatic issues are provided by mixed methods. Johnson and Onwuegbuzie (2004) argued that mixing methods allow researchers to minimize the disagreements between the positivism and interpretivism by appreciating the techniques of both quantitative and qualitative research. The main aim in mixing qualitative and quantitative methods in this research is to gain an ability to make generalizations by using a larger sample while also obtaining a deeper understanding into the concept of public stigma towards mental health problems in the two communities via the use of a smaller sample.

Similarly, Saglam and Milanova (2013) also stated that there are several factors that play a role in increasing the use of a mixed methods technique in social science research. Firstly, many researchers aim to benefit from the strengths of both qualitative and quantitative research methodologies. In the case of trying to address complex social realities such as stigma, it is more appropriate to use mixed methodologies allowing researchers to ease the complexity of the phenomenon. In addition to these, combining the two methodologies might give a better insight to the phenomenon being studied by the researcher. Moreover, researchers argue that use of the quantitative and qualitative methodologies together in one project helps them better appreciate their results by allowing

detailed explanations, understanding and expansion of what they have obtained from each of the methodologies that they used (Creswell & Clark, 2007).

Although many advantages of conducting a mixed methods research had been noted, its possible disadvantages should also be acknowledged. Researchers should also be aware of the cost and the time consuming nature of the mixed methods research as opposed to a mono-method (Creswell & Clark, 2007). Niglas (2004) noted that because it requires implementing different methods in one study, mixed methods research is generally more time consuming. Furthermore, it has been noted that researchers using a mixed methods approach in their research must be competent in both qualitative and quantitative methods. Additionally they might also find it challenging to publish their mixed methods studies due to word and page limits in most of the journals (Hanson, et al., 2007).

Researchers adopting this approach also need to have a sufficient knowledge and understanding about the methods that they are using in order to be able to appropriately mix them (Curry, Nembhard & Bradley, 2009). It is a difficult approach to apply in a single study because one needs to justify its application with their research questions, and their analysis (Curry, et al., 2009). To this date, there are some unresolved issues surrounding mixed methods research, which the researchers need to be aware of. For example debates around mixing the paradigms, the way to interpret and two different types of data (Johnson, 2007).

4.7 Steps in Conducting a Mixed Methods Research

Similar to the traditional research methods, a number of steps are also required when designing a study using mixed methods; clarifying the aim of the study and

determining the research questions, deciding on what type of data to collect. Researchers such as Creswell (1998); Greene and Caracelli (1993); Morgan (1998); Tashakkori and Teddlie (1998) noted that in a mixed methods research, there are additional three steps to be considered by researchers. These are decisions around whether to adopt a precise theoretical perspective or not, data recognition, collection and analysis and finally deciding on the procedures to be carried out to integrate two different kinds of data (Creswell, 1998; Greene & Caracelli, 1993; Morgan, 1998; Tashakkori & Teddlie, 1998). These sequential steps are fundamental for researchers who adopt mixed methods to consider prior to carrying out their studies as these have an impact on the research process (See Table 4.7.1).

In more detail, Crotty (1998) stated that it is important for researchers to decide if they want to take a philosophical standpoint or paradigm that will create the basis of their study, consequently impacting on a methodology that they choose. Considering the fact that most researchers will adopt a theoretical basis and form hypotheses in their examinations, the initial stage for every researcher must be to decide where they would stand in regards to a paradigm.

At the second stage, researchers must decide in which order they will be collecting the data; qualitative-quantitative or vice versa, parallel or after one another. Researchers should also consider the priority, which will be given to the each type of data (Creswell et al., 2003; Morgan, 1998). Once these steps are taken and the data collection has ended, researchers must then decide at which point they would like to start the data analysis and integration. Researchers can adopt different strategies at this stage. For example, they can decide to analyse their data separately or in parallel (Caracelli & Greene, 1993; Onwuegbuzzie & Teddlie, 2003; Tashakkori & Teddlie, 1998). If the results are analysed

separately, researchers may choose to compare and contrast the data obtained via the use of a quantitative technique and the data obtained via the use of a qualitative technique. They may also choose to convert the qualitative data obtained through interviews by counting the frequency of emergent themes for example, and then compare these to the quantitative data obtained via the use of a survey. In the current project quantitative and qualitative data will be collected separately to complement each other.

Table 4.7.1

Summary table of the steps to be followed when conducting a study using mixed methods

1) Determine the research question and assess the appropriateness of the use of a mixed methods approach in addressing the research problem.
2) State the rationale of using a mixed design.
3) State the mixed methods design which you are going to use; explanatory exploratory, triangulation, embedded or mixed model research.
4) Detailed description of the aim of the mixed methods study.
5) Preparation of the research questions in order to be addressed with the use of qualitative and quantitative techniques.
6) Data collection.
7) Data analysis.
8) Data Validation.
9) Writing up.

4.8 Pragmatism Paradigm Explained in Detail

The basis of pragmatism had emerged with the idea of John Dewey, Richard Rorty (1986) and Donald Davidson (1974). According to pragmatists, in order to gain the most accurate understanding of the research problem one must adopt “what works” (Patton,

2005; Rossman & Wilson, 1994; Tashakhori & Teddlie, 1998). Maxcy (2003) also noted that, pragmatists prioritise research questions more than the methods used in order to address the research problem.

In general, it is defined as the philosophical basis of the mixed methods approach. It enables researchers to make a set of assumptions about knowledge, consequently establishing the basis of mixed methods. This separates it from the pure quantitative and qualitative paradigms (Johnson & Onwoegbuzie, 2004; Maxcy, 2003; Rallis & Rossman, 2003). Four different views about how pragmatism forms the basis of mixed methods research have been identified. It should, however, be noted that there may be some overlaps amongst these views. Some suggest that pragmatism enables the unification of the approaches that are considered to be different from each other. Researchers supporting this view challenge the idea suggesting the incompatibility of quantitative and qualitative paradigms. They advocate the common grounds amongst these two methods (Datta, 1994). Tashakhori and Teddlie (2003) noted that some perceive pragmatism as a concept that create a third alternative for researchers who think adopting a pure quantitative or qualitative method will not provide a sufficient information about the concept being explored.

Contradicting with this, some researchers, however, believe that pragmatism is a new unique belief, which allows researchers to mix methods from different paradigms. According to these researchers it is not possible to carry out a good social research without using a mixed methods approach (Rocco, Bliss, Gallagher, Pérez, & Prado, 2003). In some cases, however, pragmatism is referred as "*expedient*". This is due to the common use of word "pragmatic" which suggests lack of standards. There is a danger with associating the

word “pragmatic” with a mixed methods design as this may result in some perceiving it as an approach where “anything goes”. It should, therefore, be emphasized by the researchers using mixed methods that this is not the philosophical underpinning of the pragmatism, and, therefore, should not be linked with mixed methods.

As opposed to positivism and interpretivisim paradigms, pragmatism has a different approach to obtaining knowledge and pragmatists prefer to use “what works” in order to solve the problems (Patton, 1990). To them, methods are important, however, the research problem and solving it is more crucial. Pragmatists, therefore, use different approaches are to better understand the phenomena, which is being studied (Rossman and Wilson, 1994).

4.8.1 Suitability of the Pragmatism Paradigm to this Project

After considering different paradigms as discussed in the beginning of this chapter, researcher decided to adopt the pragmatism paradigm as a philosophical basis in this thesis. According to Cherryholmes (1992), this paradigm allows researchers to freely combine and draw conclusions from both quantitative and qualitative methods. It enables researchers to select from a wide range of methods, techniques and procedures that can best answer their research questions and problem(s). Individual researchers have a freedom of choice; they are "free" to choose the methods, techniques, and procedures of research that best meet their research aims and objectives. To pragmatists, truth is obtained through what works in certain times and situations. For the pragmatists “what” and “how” are two important concepts depending on their studies’ intentions. These are some of the reasons to why pragmatism enables the use of multiple methods, different worldviews and assumptions in one research project.

Thus it is the researcher's belief that adopting this paradigm will allow her to appreciate both quantitative and qualitative approaches in this thesis consequently enabling her to capture a better picture of mental health related stigma in Turkish and Greek speaking Cypriot communities and constructs in relation to stigma. There are, however, certain issues in every research that need to be considered by the researcher and these include ontological, epistemological, theoretical, methodological and ethical considerations. In the next section of this chapter researcher will be focusing on these issues in relation to this thesis.

4.8.2 Ontological Issues/Considerations in Research

Before the researcher explains what type of ontology underpins this thesis, it is necessary to define what ontology is. Ontological issues are related to the description of reality. Two main distinctions of the ontological propositions are positivism and interpretivism. According to the positivists, the reality is independent, on the other hand, for the intepretivists, reality is created through social processes (Newman, 2003). Bassey (1995) suggested that for the positivists, reality is a concept that exists and needs to be explored using scientific means. Cohen, Manion and Morrison (2000) noted that positivists do not perceive themselves as playing an important role in research and they remain fairly detached from it. They argue that one can examine the world using quantitative methodologies where the results are represented in a numerical form that reflects the reality (Mutch, 2005).

For the intepretivists, humans create reality and individuals have their own understanding of these unique realities. They, therefore, use qualitative methodologies to

investigate realities unique to certain individuals. Findings are, therefore, represented in a word form. As opposed to the quantitative methodology used by the positivists who see those taking part in their research project as objects, interpretivists using the qualitative methodology see those taking part in their research as participants. Casey (1995) noted that this allows each research participant to explain the meaning of their own realities, understand them and create knowledge through them. According to Guba and Lincolin (1989) ontological assumptions are concerned with answering the questions as "what is there to be known by us?" or "what is the true description of reality?"

This study adopted a "realistic ontology" which is defined as the researcher's belief in regards to reality existing based on the cause and effect relationship. Researcher assumed that there are some realities in this research; knowledge about mental health, familiarity with mental health problems and cultural background of an individual and she believed that these realities affect the attitudes of Turkish and Greek speaking Cypriots towards mental illness. This is why she thought adopting a realistic ontology for this part of the thesis was necessary. According to Pring (2004) the aim of research is to clearly define what the situation is and/or what previously happened. Such explanations are sought by researchers in order to be able to predict what might happen in the future or what might happen if certain interventions are developed.

As stated in Chapter 1 one of the aims of this thesis was to assess the levels of mental health related public stigma in Turkish and Greek speaking Cypriot communities, and to see if these relate to factors as knowledge, familiarity and culture. In the first study of this thesis researcher, therefore, sought to understand what the current situation is in both of the communities in regards to the level of public stigma and what constructs relate to

these levels. Researcher assumed that both negative and positive attitudes could be attributed to knowledge (high/low), familiarity (high/low) and cultural structure (individualist/collectivist) of the participants.

In the second study, researcher needed to appreciate the use of ontology that is necessary of a social world of meanings. In this sense, she believed that the world is filled with human beings and each one of them has their own thoughts, beliefs and interpretations about certain phenomenon. For this reason the reality was explored via the use of interpretive approach; semi-structured interview. Thus allowed the researcher to gain a better insight into the participants' opinions, feelings, experiences and thoughts in regards to mental illness as well as how these may explain their attitudes.

4.8.3 Epistemological Issues/Considerations in Research

In general, epistemology is concerned with the association between what is known and the individual who knows the phenomena (Cohen, Manion & Morrison, 2013). For the positivists/quantitative purists, scientific clarification is the main reason to conduct research. Benz and Newman (2008) noted that the positivists perceive social science as a way to organize methods, and carry out scientific observations of human behaviour in a deductive manner. This then helps them to explore and approve certain predictions in regards to general human behaviour. According to the positivists there are pragmatic realities, which are independent from subjective ideas or perceptions, and are managed by cause and effect. One can, therefore, add on to the social realities that are stable (Newman, 2003). Ulin, Robinson and Tolley (2012) also stated that the aim of science is to form methods that are objective in order to predict reality appropriately. To them, the only way

to obtain a reliable knowledge is through an objective assessment of a concept; generally through experimental techniques.

Maxwell and Loomis (2003) noted that unlike the positivists, intepretivist/qualitative purists perceive world as created, interpreted and experienced by an individual. They explained reality as being created through one's interaction with others in the society. They, therefore, argue that the aim of research is not to generalise the phenomenon to a wider population but to understand it from a perspective of an individual (Farzanfar, 2005). Due to this, qualitative research methodology requires a closer contact between the researcher and the group, which the researcher is interested in over a certain period of time. This can lead to more in-depth and richer information about the concept being studied. Ulin, Robinson and Tolley (2012), therefore, suggested that unlike the quantitative methodologies, qualitative ones are inductive and more concerned about gaining an in-depth understanding about the unique issue rather than generalizing it.

It should, however, be noted that both positivists and intepretivists perceive human behaviour as possibly having related patterns (Newman, 2003). They, however, differ in their perceptions about how these patterns are created. Whilst positivists suggest that they are products of cause and effect, interpretivists argue that they are formed through social interactions. As interpretivists argue that world experience is subjective, they want to understand such experiences by allowing the individual participants to freely speak about the phenomena being explored. This enables them to gain a deeper understanding of what the participant has experienced about the phenomenon being studied (Newman, 2003). For the intepretivist, trustworthiness and credibility are the two issues that should be considered. For the positivists, knowledge can only be obtained by true measurements such

as questionnaires and psychological tests with specific questions about the phenomena. To them, validity, reliability and objectivity are the main issues that should be considered while carrying out research.

In public health research as mental health related stigma, the gold standard for research evaluation is the statistical significance found via the use of quantitative indicators (van Brakel, Voorend, Ebenso, Cross & Augustine, 2011). As more concerns were raised in regards to human rights, some researchers started to argue that using only the quantitative indicators do not give researchers an adequate understanding of the situation.

Violation of the human rights of individuals with mental health problems is well recognized and documented globally (Ngui, Khasakhala, Ndetei, & Roberts, 2010). As mentioned in Chapters 1 and 2 pevious literature suggests that many are discriminated and isolated as a result of their illness (Corrigan, 2002; Dako-Gyeke, Dako-Gyeke & Asampong 2015). Such negative attitudes towards these individuals are influenced by factors such as culture, ethnicity, language, education, and religion. Although establishing levels of stigma is possible via the use of quantitative techniques, understanding concepts influencing these levels, as culture is needed to be explored more in depth using qualitative approaches.

The epistemological stance adopted in the first study is the objectivist epistemology, which means that the study object is separated from the researcher. Knowledge is obtained through direct observations or measurements of the concept being studied; in this case stigma. Facts are proven by examining the components of the phenomena that is being assessed (Coll & Chapman, 2000; Cousins, 2002). In the first study the researcher, therefore, separated herself from the objects that she studied. As well as assessing the levels

of stigma in both of the communities, she also investigated at the impact of knowledge, familiarity and culture on stigma levels of Turkish and Greek Cypriots. This was achieved via the use of various questionnaires and statistical analysis. Researcher then made claims in regards to the way things really are (Pring, 2004); whether stigma of mental illness exists or not, to what extent it exists, what factors relate to it and how the two communities differ from each other in regards to their attitudes towards mental illness consequently the levels of mental illness stigma.

As for the second study a constructionist epistemology, which refers to a view that all meanings and realities are constructed by the interactions between human beings and their world, was adopted. In the second study the researcher initially aimed to understand, 'the ways which knowledge, familiarity and culture influenced attitudes consequently stigma towards mental illness' She then constructed meanings/realities from the interviews, which she conducted on a one to one basis with the participants. These meanings were not represented as truth but instead an invitation for others to interpret.

4.8.4 The Theoretical Perspective of the Researcher

Crotty (2003, p.7) defined the theoretical perspective as a *'standpoint, which determines the methodology of the research'.* Thus theoretical perspective that researchers adopt provides them with a rationale and criteria for their research as well as informing the research process that they need to follow. Considering the ontology of the first study is concerned with reality and knowledge being purely based on measurable facts (Tashakkori & Teddlie, 1998), researcher argued that the theoretical perspective of it is positivism. It is also theoretically positivist because it adopted a cross sectional design of research; the

researcher desired to establish casual links between certain variables and, further to these, certain hypotheses were generated prior to data collection which were verified using statistical analysis of data.

As for the second study the researcher was more concerned with the meanings and interpretations that individuals construct about the social world and so a constructionist epistemology was adopted. It was, therefore, logical to adopt an interpretivist theoretical perspective for the second study. In researcher's belief it was interpretivist in a theoretical sense because the researcher aimed to understand the meanings and interpretations that are created by individuals (Becker, 1970). Manipulation, measurement or generalizations of the findings were also not intended in this part of the thesis (Hamersley & Atkinson, 1983) but to explore and understand participants' thoughts and perceptions in regards to mental illness and stigmatization of these conditions. In support to these explanations Cohen et al. (2002) noted that the uniqueness and non-generalizable nature of the individuals, existence of multiple interpretations, therefore, multiple realities of a single situation. He also emphasized the need of examining such situations by asking participants directly.

4.9 Methodological Assumptions

Another issue to be considered by every researcher when exploring the phenomena is methodology. According to Crotty (2003) methodology could be seen as a strategy, a plan or as a design that links researchers' method preferences and the outcomes that they desire. Sarantakos (2005) also defined methodology as a strategy, which transfers the ontological and epistemological principles into standards, consequently helping researchers to develop a way to carry out their research. For the positivists a quantitative methodology

is required which includes realist/objectivist ontology and empiricist epistemology. This requires researchers to be objective and de-attached from the research process where the variables are measured and hypotheses are tested using causal explanations. For this purpose experimental designs are generally used in order to measure the effect by observing the changes in different groups.

For the intepretivists, a qualitative methodology is required which consists of constructionist ontology and epistemology as well as interpretive theoretical basis. Participants' experiences are, therefore, key to understanding the concept that is being explored. Those who use qualitative methodologies, therefore, are more involved in the research process because they see themselves as a part of a group or culture that is being studied through interviews, life stories and/or analysis of already existing documents.

In psychology, however, qualitative research has previously been undervalued for being more subjective. In stigma research, on the other hand, qualitative approaches can help researchers to gain a better understanding about the concept by providing rich descriptions and explanations of individuals' perceptions of mental health problems. Particularly in societies such as Turkish and Greek speaking Cypriots where there are strong sense of cultural values, traditions and customs, using a qualitative methodology facilitates a better understanding of the stigma concept (Bos, Pryor, Reeder & Stutterheim, 2013).

For example, in a qualitative study conducted by Chambers et al., (2015) that looked in to the HIV and Aids associated discrimination and stigma showed the beneficial use of such approaches on understanding public stigma. In their article Chambers et al.

(2015) noted that evidence that comes via the use of a qualitative technique is particularly useful in understanding socially constructed concepts as stigma; more specific to this thesis, stigma of mental illness, in interpreting social processes and interactions. When investigating and trying to understand the concept of stigma, the use of qualitative approaches along with the quantitative ones is, therefore, encouraged by previous researchers.

The first study of this thesis adopted a non-experimental research method. For this purpose a cross-sectional design was used. Data was collected using a survey technique that was then analysed using statistical techniques namely Correlation Analysis, Principal Component Analysis (PCA) and Factor Analysis. For the first study, four questionnaires along with a demographic form (See Appendix 4) were given to the participants; knowledge scale (See Appendix 5), familiarity scale (See Appendix 6), attitude scale (See Appendix 7) and cultural scale (See Appendix 8), which then enabled researcher to first establish participants' attitudes towards mental illness. She was then able to examine the relationship between demographic, knowledge, familiarity and culture variables with the attitude variable.

In the second study of this thesis, an interview method was used in order to understand Turkish and Greek speaking Cypriot participants' experiences with, feelings and perceptions of, and thoughts about mental health and illness in general. In line with the findings of the quantitative studies (See Chapters 5 &6) researcher designed an interview protocol that included questions in regards to the participants' cultural background, their knowledge on mental health and mental health problems as well as their perceptions of individuals with mental illness. Participants' familiarity with mental illness but more

importantly the source of familiarity with such conditions and its possible influence on their attitudes were also be explored. For example "Thinking about your own community in your experience, how do people who do not have mental illness perceive those who have mental health problems?" The interviews were transcribed and analysed using an Interpretive Phenomenological Approach (IPA), which will be explained in detail later in this chapter.

4.10 Ethical Considerations

Pring (2000) defined ethics, as a code of conduct that every researcher needs to follow. Similarly, Clisha (2005) emphasized the codes of conduct that are aimed to protect participants being studied as well as the researchers from any physical, mental and/or psychological harm. As explained by the British Psychological Association (2009) ethical research conduct refers to a set of moral principles that allow researchers to apply informed moral reasoning. As introduced by the Declaration of the Helsinki code of ethics (2013) and widely adopted by those who work with human participants the following principles had also been adopted in this thesis; Respect for the Autonomy and Dignity of Persons, Scientific Value, Social Responsibility, Maximising Benefit and Minimising Harm.

4.10.1 Respect for the Autonomy, Privacy and Dignity of Individuals, and Communities

In the context of research, having respect for the autonomy and dignity of persons refer to researcher's duties to his/her participants. It is the psychologists' duty to respect individual differences and cultural backgrounds. These differences may include; age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race (including colour, nationality, ethnic or national origin), religion and belief, sex, sexual

orientation, education, language and socio-economic status. For this reason it is important for psychologists to explain the true nature of their study which participants are asked to take part. This ensures fair and non-discriminatory practice.

In order to ensure fair and non-discriminatory practice participants who took part in the studies of this thesis were given an informed consent form prior to taking part in both quantitative and qualitative phases of this thesis (See Appendix 1 & 2). The information sheet (See Appendix 1) further included their rights to withdraw from the research process at any time without giving a reason. Once they have read and understood the information presented to them they were further asked to consent their willingness to participate via the use of a Consent Form (See Appendix 2). In addition to this researcher took steps to ensure anonymity of the participants as well as the confidentiality of the data collected. Allocating pseudonyms to the participants for both quantitative and qualitative studies ensured anonymity of participants. It should, however, be noted that participants who were willing to take part in the second part of the study were asked to provide their contact information in order for researcher to be able to contact them at a later stage. Participants were, therefore, asked to provide their phone numbers, which were stored by the researcher in an encrypted document with a secure password, which only the researcher had accessed to. Although participants' phone numbers were not enough to identify them, researcher believed that protecting the information with such precautions ensured full anonymity of the participants. For the qualitative part of the study, due to having recorded participants' voice researcher ensured the anonymity by changing the participants' voice via the use of an application called 'MorphVox'. Moreover, storing the questionnaires collected from the participants in a locked drawer out of the reach from anyone else but the researcher ensured

confidentiality of the quantitative data. The voice documents were also stored as a file in a USB, which was kept along with the questionnaires in a locked drawer.

4.10.2 Scientific Enquiry and Social Responsibility

This project was undertaken in an effort to contribute to the scientific literature. As mentioned earlier in this chapter it is the researcher's belief that this project is unique in a sense that it is the first of its kind to be carried out with the Turkish and Greek speaking Cypriot communities of Cyprus. There has not been any previous research carried out in the field of mental illness stigma that included both of the communities. For this reason this research carries great importance that will hopefully allow increase knowledge within the field of mental illness stigma and also aid the development of effective strategies to diminish it in the Turkish and Greek speaking Cypriot communities. In order to ensure good standards researcher had carried out an exhaustive literature search to ensure that such project had not been previously done and also the chosen methodology had met the expected quality and standards. For this reason an ethical approval application was made to the Middlesex University of London and researcher was granted prior to data collection. Within the ethical approval forms the aims of the research were explained as transparent as possible to ensure that the committee can be clear on researcher's intentions. A risk assessment was also submitted to the ethics committee that covered the potential risks of the study and should they arise the protocols for addressing such difficulties were also noted. In relation to the Social Responsibility principle it is believed that this research will contribute the 'common good' as the findings of this research will help increase awareness about mental health problems within the general public but also enable necessary steps to

be taken to improve the quality of lives of those with mental health problems. Through carrying out this project it was also the researcher's intention to contribute to the field by generating psychological knowledge.

4.10.3 Maximising Benefit and Minimising Harm

When carrying out research projects it is the researcher's responsibility to consider it from various standpoints; participants, groups or communities that may be affected by the research. It is the researcher's responsibility to ensure the potential risks to psychological well-being, mental health, personal values, and the invasion of privacy or dignity are avoided. It is, therefore, necessary to ensure that the benefits are maximised from the beginning to the end of the project. In order maximise the benefits, researcher initially determined the possible risks before starting this thesis. She ensured that the participants were not exposed to risks greater than to those in ordinary lives. Due to the nature of this project and in line with the research aims and objectives, participants were asked questions that are considered to be sensitive for the Cypriot community. Particularly during the qualitative study conversations around the traumatic war experiences have aroused which may have caused participants to feel uncomfortable during and after the interviews. As well as the sensitive conversations that were held during the qualitative phase of the project, the scenarios, which were used in the quantitative study, could have also lead participants to stress. This is because they were asked to imagine a person who was hospitalised and was having some symptoms, which could be defined as stressful. In order to minimise the possible stress that may be experienced by the participants during and after their participation, researcher had provided them with the help-line numbers in their respective communities so that they could seek advice in case they felt uncomfortable (See Appendix

1 & 2). Furthermore both the researcher's and the supervisors' contact details were given to the participants to use if they had any questions in regards to the study and wanted to discuss with either the researcher or the supervising committee. Moreover as mentioned earlier participants were informed about their rights to withdraw from the study if they did not wish to continue.

As previously mentioned an informed consent form was also taken from the participants in an effort to minimise any potential risks. This meant that participants knew the nature of the study before they agreed to take part. They were informed about the aims, methodologies that were going to be used, benefits and the potential risks of the study. Participants were also informed and assured of confidentiality and were told about what will happen to their data. There was also a statement that explained to them the time associated with the participation to the study. In order to minimise the risks researcher had arranged the time and place that was most convenient for the participants to collect data. Participants also had the chance to request their data to be destroyed even after they completed the qualitative phase of the study. Furthermore, no deception was also used in this study and for participants' consents to be valid researcher had required all participants to be over the age of 18 and not to have any known mental illness. Finally a written debriefing form (See Appendix 3) were handed out to the participants at the end of each study that re-stated the aims and objectives of the study along with the ways which researcher adopted to protect anonymity of the participants and the confidentiality of the data collected. The debriefing forms also included a statement that thanked participants for their contributions and also the researcher's, supervisory teams' and the help-line's contact details for them to contact (if they wished to).

4.11 Evaluation of the Mixed Methods Research and Techniques to be used

Charles and Mertler (2002) noted that mixed methods research is constructed through the use of both quantitative and qualitative approaches. Quantitative studies can be descriptive if a researcher is only interested in the relationship between the variables. They can, however, also be experimental if the aim is to determine causality. In order to be able to make generalizations about the population, the sample and the size should be large. Different types of quantitative designs exist; experimental, quasi-experimental, correlational and survey. Prior to the data collection the researchers determine the dependent, independent and control variables (Creswell, 2005). The data is then collected with instruments that are either existing and tested or self-developed by the researcher.

For the quantitative part of the thesis, an exploratory correlational quantitative study was carried out. The researcher aimed to recruit a large number of participants from both Greek and Turkish speaking Cypriot communities who were asked to complete four different questionnaires assessing attitudes towards mental illness and factors associated with it; knowledge, familiarity, attitude and culture (See Appendix 5,6,7,8).

Qualitative research, on the other hand, perceives reality from the constructivist point of view consequently arguing that there are multiple realities, which are specific to each individual experience (Denzin, Lincoln & Giardina 2006). Creswell (2007) noted that natural settings are used to carry out the study where researchers are able to obtain in-depth information from the participants about their views on the topic being explored. Once the analysis is completed researchers are then able to provide a complex and holistic picture of the topic. Unlike the quantitative research, in qualitative one the research questions are kept

open and more general, consequently allowing participants to express their views and experiences on the phenomenon (Patton, 2002). Case study, phenomenology, grounded theory, ethnography and narrative research are the main research designs used in a qualitative research (Creswell, 2007). Qualitative researchers aim to interpret the meaning of findings and reflect on these interpretations (Lincoln & Guba, 1985).

A qualitative study was carried out following the quantitative one for this project. The aim was to gain a better understanding of the findings from the quantitative study. For this purpose semi-structured interviews were carried out with some of the participants (See Appendix 9). The results were then analysed using an Interpretative Phenomenological approach.

Semi-structured life world interview has been used as a powerful data collection method to provide scientific knowledge in order to enable researchers to understand human behaviour for many years (Kuale, 1996). Many famous theories such as Freud's Analytic Theory and Piaget's theory of Child Development had been constructed with the use of such approach. In his book Kuale (1996, p.30) also stated that the aim of semi-structured interviews *"is to obtain descriptions of the lived world of the interviewees with respect to interpretations of the meaning of the described phenomena."* The use of such approach has particularly been deemed appropriate for this project when considered the aims and objectives of it; to understand the perceptions of mental health problems in Turkish and Greek speaking Cypriot societies, why such perceptions exist, and how they are formed.

In support to this, Gillham (2004) noted that the interview approach is best when the aim of the researcher is to understand and explain rather complex concepts such as stigma

where many factors may be involved in its formation and, therefore, should be considered and studied in a great detail. Further to these, Gillham (2004) also noted that an interview technique is one of the best techniques that provide a rich set of data where the focus is to understand the thoughts, reasons and motivations behind one's attitude, belief and behaviour. Moreover, it is the researcher's belief that the use of a semi-structured interview technique in this thesis was advantageous particularly when considering the fact that there is limited research on stigma of mental illness in the Greek speaking Cypriot community and no research available in the Turkish speaking Cypriot community on that matter.

Finally, stigma of mental illness is a sensitive subject to study, as perceptions of mental illness still remain fairly negative in many communities (Papadopoulos, 2009). Gilham (2004) noted that in such situations where sensitive topics are involved individual semi-structured interviews are particularly appropriate as participants are more likely to feel comfortable knowing that they are in a non-judgmental environment, consequently allowing them to open up more and obtaining richer data. In such cases new and more recent knowledge is also likely to emerge that is needed in the case of Cyprus as currently there is very limited or no research available.

IPA was selected as a way to analyse the interviews. According to Smith (2004) Interpretative Phenomenological Analysis is a qualitative research technique that seeks out to explore and understand one's experiences of the construct that is being studied. To Smith (2004), this method allows researchers to appreciate different perspectives that participants bring in to the research process by examining their own worlds, unique experiences and interpretations as well as the meanings attached to such experiences.

Initially, this technique was introduced by Jonathan Smith as a complementary approach to both qualitative and quantitative methodologies in the field of psychology in his paper published in 1996. The IPA method has attracted much attention through the following years particularly from the field of health, social and clinical psychology (Smith, Flowers & Larkin, 2009).

Previous research has shown that there are diverse experiences of those living with various health conditions which could be better understood with the use of IPA such as childhood illnesses (Petalas et al., 2009), people with intellectual disability (Clarkson, Murphy, Coldwell & Dawson, 2009), those with dementia (Clare et al., 2008) and individuals with psychosis (Quin, Clare, Ryan & Jackson, 2009). Although in many cases IPA is thought to be a disease or impairment oriented approach, new research is emerging that shows the use of this technique in understanding attitudes, attributes towards certain health conditions as mental illness consequently enabling researchers to also develop effective strategies for positive change in communities (Reynolds & Prior, 2003; Reynolds, Vivat & Prior, 2008). Considering the aims of this thesis and the research questions it is vital that the researcher understands the unique perspective of individuals by enabling them to talk freely about their experiences in regards to mental health related stigma. IPA is, therefore, believed to be the most suited technique to be used to analyse the interviews in this project.

4.12 Theoretical Perspectives of IPA- Phenomenology, Interpretation and Idiography

According to researchers as Smith (2007) and Smith; Flowers & Larkin (2009) there are three key theoretical approaches to IPA, which are phenomenology, interpretation

(hermeneutics) and idiography. Although these approaches are not only used by the IPA users, the way they are put together in a specific manner makes IPA a unique approach in the phenomenological field. Langdridge (2007) defined phenomenology as a philosophy and a part of a wide research methods family that aims to explore and bring an understanding to the lived human experiences. Phenomenological methods allow researchers to better understand the meanings that individuals attribute to their lived experiences from everyday life. For example it can uncover the meanings of living with certain health conditions as schizophrenia or lung cancer (Langdridge, 2007). The main principal of a methodological approach is directly linked with IPA technique where participants are encouraged to speak about their own experiences using their own perspectives and words (Smith, Flowers and Larkin 2009). Where qualitative approaches such as IPA is used, a researcher carries out literature review in an effort to obtain information but also to identify the knowledge gaps within the field (Smith, 1999; Smith, Flowers & Larkin, 2009). This is more in line with Heideggerian philosophy where the pre-defined theories and assumptions are set-aside at the research design stage. This facilitates a non-biased exploratory data collection that is participant led (Smith & Osborn, 2008). In their research Royal, Reynolds and Houlden (2009) used IPA to understand the experiences of those returning to work after Guillian-Barre syndrome. Their research highlighted the challenge that participants faced due to the responses they received from their colleagues and culturally acceptable, norms, behaviour and appearance. It is, therefore, said that IPA does not only help researchers to identify the experiences from one's perspectives but also to explore the influence of culture, society and history on such lived experiences (Eatough & Smith, 2008). Following this it was the researcher's belief

that due to the personal and social focus of IPA more in depth and detailed analysis and interpretation in regards to stigma of mental illness in the two communities were extracted in this thesis.

Hermeneutics is another key theoretical perspective of IPA, which can be defined as the theory and practical application of the meanings obtained from participants (Cassidy, 2010). Various theoretical perspectives of hermeneutic theories are needed to be understood when trying to appreciate the interpretative nature of IPA. Three of the most well-known hermeneutic theorists are Schleiermacher, Heidegger, and Gadamer (Smith, Flowers & Larkin, 2009). Scheleiermacher, a theologist who mainly interpreted the biblical material had noted that the detailed linguistic and psychological interpretation of the transcript would allow researchers to thoroughly understand the meaning of the text as well as the unique motivations of the individual. This approach could be thought as a holistic one that aims to bring together pieces that are being given by the participant throughout the interview (unique motivations) as well as the whole (context) meaning of the text. Considering the main perspective of IPA that suggests every individual has their own way of experiencing a certain phenomenon that is lived within a shared context, it is possible to see how the Schleiermacher's theory had influenced and created a standard for those wishing to use IPA. In addition to these Shchleiermacher also noted that informative analysis of the data involves in psychological and linguistic interpretation of the text given from a unique individuals' perspectives. Thus in order to understand the true meaning of one's experience of the phenomenon researchers need to go beyond what is being said and look for the meanings which individuals attach to their experiences (Smith, Flowers &

Larkin, 2009). This had become one of the main focuses of IPA researchers whose aim to gain a deeper understanding of a certain construct.

Another influential theorist in the field who developed Schleiermacher's theories of interpretation further was Heidegger. He argued that people belong to a world that consists of things, language, relationships and culture. All these inevitably affect one another and form a perspective that is unique to an individual. To Heidegger it is, therefore, impossible for researchers to understand a phenomenon without asking, questioning and carrying out a thorough linguistic and psychological interpretation as suggested by Schleiermacher (Larkin, Watts & Clifton, 2006). Different than Schleiermacher, Heidegger also noted that as well as the participants' researchers' previous experiences, languages and cultural beliefs impact on the whole IPA process. For this reason the starting point of any enquiry is actually the enquirer's perspective of his/her own experience. According to the researchers using the Hideggerian approach, one must first acknowledge their own perspective and identify their own understanding of the phenomenon they are interested in (Smith, Flowers & Larkin, 2009). This makes IPA a sensitive and responsive approach in regards to data collection and analysis where the researcher's perceptions are acknowledged as well (Larkin, Watts & Clifton, 2006). To IPA researchers, prior experiences carry a great importance as they form assumptions, which in turn form the basis of the questioning and interpretation (Moran, 2000).

Following these arguments of the theoreticians Smith, et al., (2009) explained the interdependence of interpretation and phenomenology as a vicious cycle. To them, no interpretations could be made if there is no phenomenology and a phenomenon cannot be identified if there is no hermeneutics. It should also be noted that the main aim of the IPA

researchers is not to bring out a definite and objective understanding of the phenomenon. It is to gain access to the way participants make sense of their real life experiences through their own narratives (Smith & Osborn, 2008). Parallel to this argument, one can think about the negative attitudes towards mental illness and individuals with mental health problems as a phenomenology and although attitudes are shared amongst public members, the reasons behind these can vary. It is, therefore, vital that one explores shared understandings from the participants' perspectives by adopting a hermeneutic approach.

Idiography is the final theoretical perspective IPA adopts and, therefore, needs to be given credit in this chapter. Idiography refers to the importance given to unique and different experiences of individuals being recruited in order to gain insight into a certain phenomenon and the unique context that the experiences takes place in (Eatough & Smith, 2008). With this an emphasis is placed on identifying and setting aside the first participant's case to the inquiry in order to appreciate each individual's unique case (Smith, et al., 2009). It should, however, be noted that this idea of separating and keeping the cases separate had changed over the past years. According to Smith and Osborn (2003) it is necessary for researchers to appreciate the uniqueness of each experience, however, the first one should be used to inform the following analysis of the others. At the final stage of their analysis, researchers try to understand these unique experiences of a particular participant but also develop more general themes (Smith & Eatough, 2006).

In his early study for example Smith (1999) focused on the lived experiences of those becoming a mother. For this purpose three participants were recruited and semi-structured interviews were carried out with them. Through the analysis of their interviews, Smith (1999) had noted that all of the participants brought out 'identity' and 'familial roles'

as shared themes, however, their experiences in relation to these themes differed. For example while one brought up her distant relationship with her husband after becoming pregnant, the other had mentioned the complex relations that emerged after pregnancy in her family. Although a single main theme was extracted as a result, each participant's experience was different and hidden in his or her own unique transcript. The emphasis put on the exploration and understanding unique perspectives of the participants had made some researchers to question the generalizability of the results of the IPA studies. It should, however, be noted that IPA researchers do not underestimate the group studies with larger populations and they also want to enable making more general claims. To them, however, these general claims need to be done only after careful and in depth step-by-step approach is followed (Smith, et al., 2009; Smith & Osborn, 2008).

Stephens had made further distinctions in regards to the generalizability of IPA results in 1982; vertical and horizontal. To him, horizontal generalizability refers to the findings that can be applied to various settings. Vertical generalizability, on the other hand, refers to the process whereby an interpretive theory could be build up. Through this theory building one's understanding of the researched phenomena is enhanced and an in depth exploration of it is carried out (Yardley, 2008). For this reason it is necessary for the IPA researchers to look through the previous research and its findings in order to further investigate the phenomenon, re-evaluate what has been understood and to see if there are any shared understandings. It is, therefore, possible to say that researchers using an IPA approach have a duty to carry out a through literature search and identify any connections between theirs' and others' findings in order to make the results more generalizable once

the analysis is done. As well as facilitating generalizability, this is also believed to be beneficial for bringing out a theoretical learning as well as making practical implications.

For example, in a study that looked into physiotherapists' and patients' experience of therapy for back pain using IPA had challenged the pre-existing social cognitive models in the field (Dean, Smith, Payne & Weinman, 2005). Dean e t al. (2005) reported that the existing social cognitive model did not thoroughly address the wider social context as culture when considering participants' experiences. With their research Dean et al., (2005) were better able to give account to social, personal and cultural factors that were found to be playing a significant role on the experiences. For example one of the findings had suggested that if a participant believed that his/her problem was serious he/she would not seek exercise therapy and will be more likely to take medication for it. For this reason Dean et al., (2005) argued that the clinicians must pay more attention to what their patients' beliefs are about the severity of their back problem. As a result researchers were offered valuable and recent information for the practitioners as well as the theory developers.

One of the other factors that make IPA perhaps more distinctive from other approaches is the process of data analysis. As introduced by Smith and colleagues it is based on thematic analysis with a unique attitude (Larkin, 2009). According to Smith, Flowers and Larkin (2009) data collection aims to make sense of the participants' experiences and, therefore, analysis of the data could be seen as an attempt to interpretively describe the phenomenon lived by the participants from their own perspectives. Although sometimes process of data analysis used in IPA can be referred as a more loose approach there are several stages involved which the researchers need to be aware of.

Once the data is collected researchers start to familiarize themselves with the text via reading and re-reading. Once familiarity is gained initial notes that attracted researcher's attention are then taken. These notes can vary from descriptive comments or brief words that linguistically describe the participant's style of interpreting their experiences; metaphor and repetition. At the next stage researchers can stop working with the text and use their notes to explore themes that emerges from the data they collected; emergent themes. Upon completion of this researchers can now look at the possible connections across the emergent themes to generate further 'super ordinate' themes. These are then gathered together and can be represented on a table. At the end of the analysis stage IPA researchers try to support the claims which they have made using participants' accounts on their experiences and this concludes the analysis process (Smith, Flowers & Larkin, 2009).

4.13 Possible Challenges of Interpretative Phenomenological Analysis

Although use of an IPA approach offers many advantages as mentioned previously, there are certain challenges faced particularly when researchers start analysing their data using the IPA approach. This is mainly because the narratives obtained from the participants consist of hidden and metaphorical meanings and other signals that may or not be linguistic (Smith, 2007). As well as these researchers have their own understandings of the phenomenon and their own resources and experiences, which can be referred as their own 'biographical presence'. All these can influence the way researchers interpret what is being said and, therefore, their understandings of their participants' experiences. These create a great challenge for researchers to overcome and in order to do so they need to be

open and explicit about their own perspectives while analysing and interpreting the narratives of their participants (Finlay, 2008).

The first step in uncovering the phenomenon using IPA is data collection. For this purpose researchers mainly use the interview technique that consists of exploratory semi-structured questions. The process is not static as the perspectives are understood via interacting and communicating with the participants. Data analysis then takes part after the researchers start to gain an understanding to the phenomenon from their participants' perspectives. As this happens they may want to ask further questions to clarify certain constructs and experiences. At this stage what is known as dual interpretation takes place, which involves participants' making sense, interpreting and transferring the meaning of their experiences about a certain phenomenon. Researchers then start interpreting and making sense of what is being said by the participants during data analysis and write up stages (Cassidy, 2010). Smith and Osborn (2003) referred to this process as hermeneutic circle where double hermeneutic is emphasized when two interpretations are made; one by the participants about their unique experiences and the second by the researchers when interpreting participants' narrative (Moran, 2000). For this reason the next section of this chapter will include the researcher's own reflexive account on her experiences at the beginning and during her data collection as well as analysis.

4.14 Reflexive Account-II

My interest in the topic of mental illness stigma started when I was working as a placement student at a psychiatric hospital in Northern part of Cyprus. During my time in the hospital I witnessed individuals with mental illness as well as their families being

treated unfairly. The public members were discriminating and stigmatizing those with mental health problems without realising. I came to the realisation that the public lacked awareness on this matter and this needed to be addressed in an effort to minimise stigma and improve the quality of lives of individuals with mental illness.

As I became more sensitive about the topic I realised that my experiences, beliefs and ideas in regards the treatment of individuals with mental illness may have impacted on my own expectations from the data analysis. In line with a reflexive approach I had started to keep a diary where I noted my feelings and thoughts particularly about the qualitative data analysis (See Appendix 9). After the interviews I constantly noted my thoughts, which I believed increased subjectivity in my data analysis. This helped me to ensure that I did not reflect any biased thoughts, which I have held to my analyses. In some cases I found myself feeling stressed and upset during the interviews where discussions in relation to the unfair treatment of individuals with mental illness took place. Some participants were quite open about how their relatives or friends were discriminated, made fun off and treated in an inhumane way due to having a mental health problem. I soon found myself questioning what I always thought about my own island where friendly and kind people live, who are willing to help each other regardless of their age, sex, occupation or health status.

I also realised that I held negative attitudes about individuals with mental illness myself and these beliefs were in line with my own society's thoughts on this matter. I believe that living abroad at the time and living independently in a foreign country for a long period of time helped me understand and process the new knowledge more openly which I needed to do so as part of my reflexive journey.

Further to this I also kept a reflexive journal (See Appendix 9) where I noted my thoughts and emotions. Probably one of the most challenging things that I undertook in this project was to interview my participants about the history of the island. The traumatising events were noted both by the Turkish and Greek speaking Cypriot participants. In some cases I found this very stressful to listen. As someone who received my early education in the Northern part of the island, I always heard stories about the conflict between the two communities where the Greek speaking Cypriot community had been portrayed as our main enemies. Listening to these stories from a first account, however, I could not stop feeling upset but I also felt ashamed in some cases of my own community and what they did to their Greek speaking neighbours, friends and community members. I felt like it was a necessary thing to also listen to my Greek speaking Cypriot participants' experiences of the past. This way I was able to see the situation more objectively instead of solely believing what was taught to me in school. This also made me become more neutral and objective when analysing the data. In addition to this, noting such thoughts and emotions, which I visited repeatedly in a journal, had helped me to keep more of an open mind particularly when I was interpreting the findings from quantitative with the qualitative studies together in the conclusion chapter (See Chapter 8).

Moreover, my previous research experience in the field of mental health as well as living abroad for many years had given me a chance to interact and exchange ideas with those who come from different backgrounds. This had made me more open-minded about individual differences so I was better able to keep my personal beliefs aside. This was strengthened by the conversations with other experts such as my supervisors and colleagues who worked in the field.

I particularly believe that having two supervisors from different backgrounds had also benefited me vastly. Having one from a Greek speaking Cypriot background helped me question my own beliefs and ideas further, which pushed me to do more research in the field. Having another supervisor from a British background had allowed me to see where I needed to put my ideas forward more clearly which again helped me to be able to organise many complex feelings and thoughts in writing. These experiences had also made me more flexible in trying to ignore and push aside the stereotypes, which I realised I held. Further to these over the years particularly after the boarders were opened in 2003 that allowed two communities to re-interact after almost 30 years, had given me a chance to interact with Greek speaking Cypriot friends and also with those from diverse backgrounds as Jews, Maronites and Armenians. As well as making me more flexible, this interaction inevitably helped me reshape my perceptions and thoughts when working with individuals who have different ideas, thoughts and perceptions enabling me to grow personally and enhance my self-awareness.

4.15 Debates on the combination of IPA Approach and Quantitative Approach

IPA as a qualitative approach is in line with the social constructivist world-view. This means that the main aim of the approach is to gain a deeper understanding of one's perception and single or multiple meanings, which they may give to the phenomena being studied. Because it is in contrast to the worldview offered by the quantitative approach in regards to a philosophical stance there are several debates around whether they can be combined or not. According to Teddlie and Tashakkori (2003) focus on the differences between the quantitative and qualitative approaches in regards to their world-views could in fact decrease the productivity of the mixed methods research. Others have noted that with a

philosophical grounding as pragmatism the combination of qualitative and quantitative approaches is possible (Denscombe, 2008). Many also state that more in depth and rich explanation and understanding could only come through plurality in regards to philosophical paradigms, theoretical assumptions, and methodological techniques (Cronholm, 2011). Furthermore, as discussed earlier in this chapter many now believe that holistic paradigms could and should be used depending on the research aims. Researchers, therefore, now appreciate the need for mixed methods in their study and they integrate both qualitative and quantitative methods to better understand the concept and be able to provide more detailed explanations. Qualitative research used in a complimentary manner with the quantitative one in this case could explore how participants perceive mental health in more detail, which in turn can help gain more in-depth and detailed understanding about the stigma concept and its constructs in Cyprus.

For the purpose of this study an explanatory mixed methods design, was used where the quantitative data was collected initially which was then followed with the collection of qualitative data (See Figure 4.15.1).

Figure 4.15.1
A Sequential Explanatory Model (Adopted from Amadnezhad, 2015).

Since the studied phenomenon was not well researched in the Turkish and Greek speaking communities and only a few scientific studies existed there was not much knowledge that could be used as a platform for this study. For this reason, researcher decided to carry out a pilot study that adopted a survey technique. This aimed to gain an overview of the Turkish and Greek speaking Cypriot communities' attitudes towards those with mental illness, to become familiar with the concept of public stigma and to identify the commonalities and differences between the two communities in regards to their attitudes. As well as these researcher also wanted to test the tools that were to be used as they were not used with the Turkish and Greek Cypriot communities before. The pilot study was deemed necessary for this research in order to be able to get an overview of the attitudes but more importantly to refine the methodologies for the larger quantitative study. It was, therefore, designed to mirror the setting, participants, data collection and analysis methods of the larger quantitative study (See Chapter 6).

Pilot studies are given a great emphasis by several researchers as Musill (2011) who argued that such studies allow researchers to develop or refine their sampling methods and to evaluate the representativeness of their sample as well as to test their instruments. Researchers as Musill (2011) also recommend carrying out pilot studies prior to large scaled ones in order to test the competence of the researcher within the area of study.

Particularly considering the fact that the data was collected in Cyprus while the researcher was living in the UK pilot study allowed her to consider some important

research issues as the availability of subjects, estimating the recruitment time of the participants, ways to conduct the larger scaled study and the cost of it. Further to this, the usability of the instruments was also evaluated prior to data collection in a large scaled study, which ensured the ease of their administrations during the main quantitative study. Pilot study also allowed questionnaires to be evaluated for their clarity, wording of the questions, reading level of the participants and the time required for completion.

The pilot study was, therefore, followed up with a large survey study that aimed to assess public stigma as well as to better conceptualize it in order to aid a better understanding about this complex phenomenon. This was followed up by interviews in order to get a deepened knowledge and understanding on the Turkish and Greek speaking Cypriot communities' attitudes towards mental illness and individuals with mental health problems. The most significant findings from the survey were addressed in the interviews (See Chapters 6 & 7). In this way, the research design could be seen as a funnel where the feasibility of the study was tested via the use of the pilot study then the interesting data from the large scaled survey study were selected and further deepened by the use of the interviews.

4.16 Sampling Strategy

A convenience sampling technique was used to recruit participants from the Turkish and Greek speaking Cypriot communities. The researcher used her contacts to contact different bodies such as schools, universities, hospitals, social clubs, business and local organisations as well as NGOs and local coffee shops within the two communities in order to gain access to the possible participants. Once the ethical permission was granted

researcher travelled to Cyprus from the UK where she worked and studied at the same time, to collect data.

There were several reasons to why this sampling strategy was used. Firstly the researcher needed easy access to the possible participants due to having limited time and resources. Secondly due to the sensitive nature and the length of the study researcher thought that using a convenience sampling method would ensure those who were willing to take part in both quantitative and qualitative studies would participate which reduces the possibility of participant loss. It was also not possible for the researcher to use a random sampling strategy, as she did not have any access to the necessary data for the Turkish and Greek speaking Cypriot communities. Considering these reasons convenience sampling strategy was therefore, thought to be the best suitable sampling strategy to be used in this thesis. There are both strengths as well as limitations in this sampling startegy which the researcher must understand and respond to. According to Atkinson and Flint (2001) there are several advantages of using a convenience sampling strategy that makes it a preferable choice for the researchers when the desirable methodologies such as random sampling, are not feasible. Convenient sampling allows creation of trust between researchers and the participants. This is because participants know that the permission to collect data was granted by a trusted person within their circle which as well as increasing trust may also increase cooperation in providing honest and truthful data. Considering the sensitive nature of the study, using a convenience sampling, may have increased participants' openness in their responses. Further to this, the researcher being a Turkish speaking Cypriot might have created a barrier in finding the necessary number of participants particularly for the quantitative phase of the thesis from the Greek speaking Cypriot community. Convenience

sampling strategy, therefore, allowed researcher to reach and recruit a large number of participants through mutual contacts from both of the communities for the quantitative study of this thesis.

Use of a mutual contact to recruit participants is also believed to have increased the cooperation between the researcher and the participants which carried a great importance in this thesis considering it consisted of two phases; quantitative and qualitative. As well as allowing researcher to recruit a large sample, a convenience sampling strategy also reduced the likelihood of participant loss in the qualitative phase by increasing researcher-participant cooperation.

Although convenience-sampling strategy offers the above-mentioned advantages there are some limitations to this technique, which also need to be acknowledged at this stage. Representativity is generally the central limitation of the convenience sampling, which is stated in the literature (Moore & Hagerdon, 2001). Unlike the random sampling techniques, convenient sampling method does not allow random selection of the participants. The willingness of the research subjects to participate is what the research depends on which is argued to be creating a selection bias and thus preventing the generalizability of the study findings (Cohen & Arieli, 2011). It was, however, noted in the Atkinson and Flint's (2001) article that the problem of selection bias might be addressed by recruiting a large sample of participants and by replicating the study. For this reason, prior to the main quantitative study (See Chapter 6), which consisted of a 519 participants, a pilot study with 100 participants was carried (See Chapter 5). As mentioned earlier this allowed the researcher to test the soundness of the materials that were translated to the participants'

native languages but also to be able to recruit further participants for the main quantitative and qualitative studies. Further to this, the main quantitative study can also be thought as a replication of the pilot study with a larger number of participants, that is thought to be increasing the generalizability of the findings (Atkinson & Flint, 2001).

4.17 Quantitative Study's Tools

Prior to participants filling the questionnaires the demographic information in regards to participant's age, sex, highest educational level, employment status and ethnic group that they identify with (See Appendix 4) were obtained. Participant's phone numbers and/or email addresses were also taken upon their wish to take part in the qualitative study. All the tools that were used in this thesis were translated from English to Turkish and Greek by two native speakers and then were back translated to English by independent translators to ensure the validity of the translations.

4.17.1 Mental Health Literacy Survey

Mental health literacy of the participants was assessed using two vignettes and a six-item survey (See Appendix 5). The first vignette contained information about an individual who showed symptoms of schizophrenia while the second vignette contained information about an individual who showed signs of daily stress. Both the scales contained six items, which were related to knowledge in regards to mental health problems; identification of various types of mental illness, help-seeking, recognition, support, employment, treatment and recovery. The vignettes were very similar to the one which was used by Jorm (2000), and Jorm, et a1. (1997).

4.17.2 The Attitude Questionnaire (AQ-27)

The Attribution Questionnaire was developed by Corrigan (2008) in order to enable researchers to measure stigma (See Appendix 7). It was specifically developed for organisations where individuals come to contact with those who have mental health problems. Although there are different scales available to measure mental illness stigma many of these are specific to certain constructs of stigma and do not have the statistical justification from the previous research as the AQ-27 does (Corrigan, 2008; Corrigan et al., 2004; Day et al., 2007; King et al., 2007; Kobau et al., 2010). It aims to measure ones' perceptions on mental health problems by looking at the attitudes and emotions that are generally classified as negative (Corrigan, 2008; Corrigan et al., 2004). As well as containing statements that are concerned with cognitive and behavioural aspects of stigma, Corrigan's AQ-27 scale also assesses the emotional aspect of stigma, which is another commendable feature of this scale (Link et al., 2004).

It contains 27 items, which addresses nine negative stereotypes associated with individuals who have mental illness; blame; anger, pity, help, dangerousness, fear, avoidance, segregation and coercion. It is a self-reported measure that is used along with a vignette, which briefly describes a person with schizophrenia (Corrigan, 2008). Researcher's rationale for using symptoms associated with schizophrenia was that it is one of the mental health problems and this is associated with the highest level of stigma. Researcher, therefore, believed that this enabled her to be better able to capture a more precise picture of stigma towards mental health problems (Corrigan, 2008; Corrigan et al., 2001; Huxley, 1993; Kobau et al., 2010; Li et al., 2007; Scambler, 2009). This questionnaire contains a 9 -point Likert scale ranging from 1 (not at all) to 9 (very much).

This way participant were able to express how they felt and what they though about the individual introduced to them in the vignettes (Corrigan, 2008). Previous studies reported a good reliability score for the AQ-27 ranging from .74 to .90, as well as validity (p = .001) (Brown, 2008; Pinto et al., 2012).

4.17.3 The Level of Familiarity Scale (LOF; Corrigan et al., 2001; Holmes et al., 1999)

As mentioned in the previous chapters one of the most commonly mentioned predictor of stigma towards mental illness is familiarity in the literature. According to many researchers source of familiarity could vary from media to personal contact with someone who has a mental illness (Anagnostopoulos & Hantzi, 2011; Corrigan et al., 2001). A self-reported type The Level of Familiarity Scale contains 11 statements, which identifies one's degree of familiarity with mentally ill (See Appendix 6). Participants answer these questions as 'Yes' or 'No' and the highest rank refers to high level of familiarity; 1 (never having been exposed to mental illness), 7 (medium contact) and 11 (having personal experience with the illness; Corrigan et al., 2001; Holmes et al., 1999).

4.17.4 The Horizontal & Vertical Individualism & Collectivism Scale (Singelis, Triandis, Bhawuk, and Gelfand (1995)

The scale was designed to examine cultural characteristics and it contains 4 orientations; horizontal individualism, vertical individualism, horizontal collectivism and vertical collectivism. It is a 16-Item 9 point Likert scale ranging from 1= never or definitely no and 9 = always or definitely yes (See Appendix 8).

4.18 Conclusion

To this date, there are still considerable amounts of debates often referred to as "paradigm wars" in regards to using a mixed methodology. The Pragmatist paradigm was developed in an effort to end this so called "paradigm war" and enable researchers to mix quantitative and qualitative methods in one project (Tashakkori & Teddlie, 1998). It is clear from the previous work done by different researchers that these two different paradigms can be mixed and subsequently provide a broader and more complete picture about the phenomenon being studied. For this study, researcher acknowledged the debates around using mixed methods, however, she had chosen to adopt a pragmatic paradigm and benefited from both the use of qualitative and quantitative methods together as she believed that this was the only way to gain a detailed and comprehensive picture particularly when the phenomena being searched is as complex as it was in this case.

Chapter 5- Pilot Quantitative Study

5.1 Overview of the Chapter

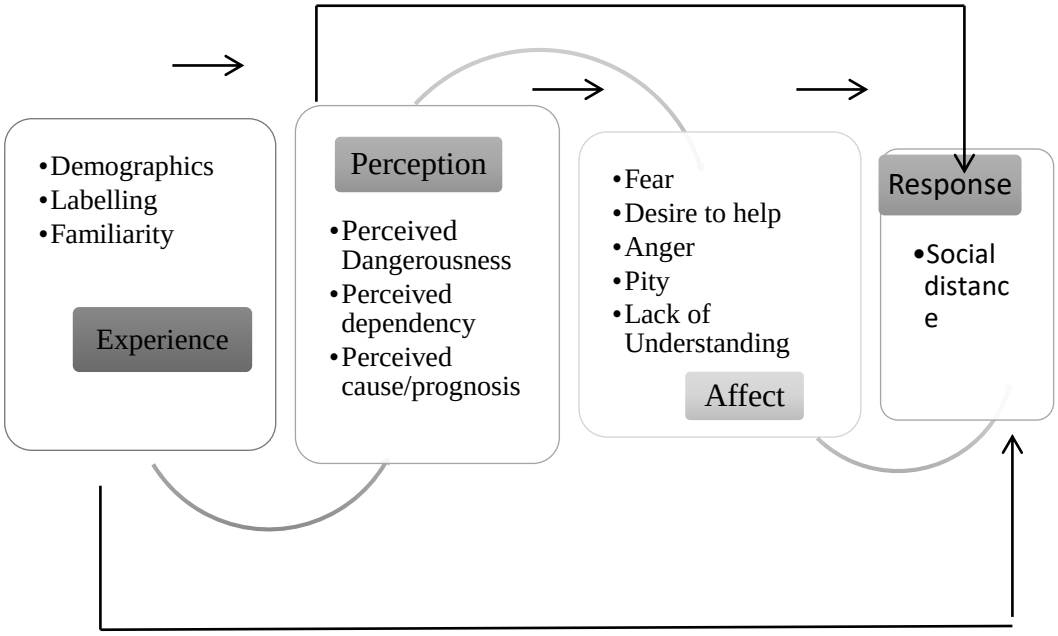
As mentioned in Chapter 4 (Section 4.15) as well as helping the researcher to have an initial understanding of the levels of stigma and the factors that relate to it within the GC and TC communities, pilot study also allowed researcher to check for the appropriateness of the procedures that were used in the main quantitative study (See Chapter 6). Further to this any technical problems that may be faced due to the translation of the scales: participants' understandings of the questions were assessed via the employment of the Pilot study. This chapter, therefore, aimed to provide the findings of the pilot study. The researcher will start with an introduction section that briefly looks at the previous research done particularly with Greek and Turkish speaking communities then move on to the explanation of the methodology that was used and the results that were analysed. A brief discussion of the findings will also be given at the end of this chapter.

5.2 Introduction

Corrigan et al., (2000) suggested that the social psychology model of public stigma claims that the stigmatizing attitudes are constructed due to one's previous experience and knowledge, which then leads to a behavioural response (See Figure 5.2.1).

Figure 5.2.1:

Pathway model of Social Distance (Angermeyer & Matschinger, 2003a, 2003b; Angermeyer & Matschinger, et al., 2003; Corrigan & Edwards, et al., 2001).



In detail, this model considers perceptions and affects as attributions, which in turn results in discrimination as a behavioural response (Emmerton, 2010). Unlike the labelling and the attribution theories, this model also considers other factors, contributing to the stigma of mental illness; for example, demographics and familiarity.

According to the previous theories of stigma one can, therefore, suggest that stigma of mental illness is a combination of the societal, personal and the cultural factors. In the case of Cyprus where different ethnic groups exist and different societal systems are in place (See Chapter 3) mental health related stigma must be understood within the unique communities as well as the whole island in order to be able to effectively address it.

According to other researchers stigma commonly results in economical, personal, political and social challenges for those who have such health conditions (Halter, 2008). When considering the negative impact of mental health related stigma, the importance of addressing it in the Cypriot community is much clearer. As well as causing the aforementioned challenges for individuals, attitudes that are stigmatizing may also result in discriminative behaviour; restriction of someone's everyday life practices as well as prospects in public and private institutions. Many researchers also suggested that stigma may prevent individuals from engaging with others in the society which in turn may worsen their condition (Vauth,Kleim, Writz & Corrigan, 2007; Mojtabai, 2010). Ajzen and Fishbein, (1980) noted that this is particularly fundamental when trying to identify the causes behind stigmatizing attitudes.

As mentioned in Chapter 3, the Cyprus conflict picked up in 1963 after the British colonial period ended. It is still ongoing to this date, as the island remains divided keeping the ethnic conflict as a hot topic. The Cyprus conflict, therefore, consists of several interacting components, which are, politics, culture, ethnicity and peoples' identity (Boatswajn, 2005; see Chapter 3). Sellers, Smith, Shelton, Rowley and Chavous (1998) argued that ethnic identity of a community include common name, shared history, cultural norms and values, language and identification with the same homeland. In the case of Cyprus, two different ethnicities; Turkish and Greek were created due to the community members' significant identification with what they considered as their motherland; Greece and Turkey. Thus making the two major societies differ in regards to their identity, culture, religion, language, education system as well as policies and regulations.

Considering the fact that stigma is socially constructed (See Chapter 2), these

differences and their impact on attitudes are important to consider. Although the borders that kept the two communities apart were opened in 2004 enabling GCs and TCs to interact again after 30 years, these differences still exist amongst the two communities. This is believed to have an impact on attitudes towards mental illness. Due to having very little research carried out in the field, much is still unknown about mental health related stigma in Cyprus; levels and how it manifests. This possesses a major problem for individuals with mental illness particularly in social and economic arenas causing inequalities (Katie, et al., 2016).

As discussed in Chapter 2 several studies that were conducted with Greek/Greek Cypriot and Turkish populations in regards to their attitudes towards mental health problems are used in this research as a starting point to conceptualize and understand the possible reasons behind it. For example, Economou et al. (2009) conducted a comparison study with the general public in Greece, Canada (Stuart and Arboleda-Florez, 2001) and Germany (Gaebel et al., 2002). According to their results, the Greek public showed a significantly higher willingness to be socially distant from individuals with mental illness compared to the Canadian and German public members. This was particularly the case when the need for intimacy in social situations was higher. In addition to this, negative attitudes were mostly found to be relating to schizophrenia, which was highly associated with criminality in the Greek society. Further to these half of the participants from Greece stated that working with an individual diagnosed with schizophrenia would make them feel uncomfortable. Unlike Greek participants, only one out of six participants from Canada and Germany stated that working with someone who has schizophrenia would disturb them.

Similarly, studies carried out within the Turkish community also report the

existence of stigma towards mental illness not only amongst the public but also amongst professionals. For example, a study carried out by Ucok, Erkoc, Atakli and Polat (2001) across nine different cities of Turkey found that practitioners held negative attitudes towards individuals with mental illness. Half of the participants in their study described individuals with schizophrenia as being dangerous and having an ability to attack children on the streets.

In a comparison study carried out by Oncu et al. (2005) also reported negative attitudes being held by the Turkish psychiatrists towards mental illness. They recruited 185 psychiatrists (79 Slovenian and 106 Turkish) who were asked to complete an attitude scale towards suicide. A comparison analysis carried out on data showed that the Turkish psychiatrists were more rejecting towards those who committed suicide. Unlike this Slovenian participants were reported more readiness to communicate and help those who came to their clinics after a failed suicide attempt.

Ozmen et al. (2004) also carried out a study, which aimed to assess public's attitudes towards individuals with depression. For the purpose of their study they recruited 707 participants from Istanbul who were required to complete a questionnaire designed by the Center for Psychiatric Research and Education to assess attitudes towards depression. The results of the study showed that the public held negative attitudes towards depression. In addition to this depression was being perceived as personal and mental weakness, which was found to have a negative impact on the participants' attitudes. Th majority of the participants also reported a willingness to avoid those with depression; more than half stating that they would not want to get married to an individual with depression, almost half stating that they would not rent their homes to and work with a person who has depression

and finally one quarter stating that these individuals should not be free in the community. Compared to other countries, such as Germany, these rates have been reported to be much higher in Turkey. For example in a study carried out in Germany it was found that 13.4% of the participants reported unwillingness to be a neighbor to someone who has depression, 16.4% for a co-worker and 34.4% of the participants stated unwillingness to rent their house to someone who has depression (Angermeyer & Matschinger 1997). This shows a stronger tendency of the Turkish public to reject individuals with mental illness compared to other European countries.

Further to these, studies done across the world suggest that the general public's lack understanding of the nature and causes of mental illness which results in stereotypical beliefs being developed contribute to the negative attitudes and subsequently stigma of mental health problems (Thornicroft, Rose, Kassam & Sartorius, 2007). For example, Jorm, Christensen and Griffiths (2005) carried out a study assessing the impact of knowledge on stigma in Australia. They compared two groups; one which received a well-organized education on depression and its treatments, while the other group did not. Upon comparing these, they found that the group that received education held more favorable attitudes, were more likely to correctly recognize and identify depression, and support professional treatment. The second group, alternatively, held less favorable attitudes towards depression and its treatment.

In Sorsdahl and Stern's (2010) study, it was found that most of the South African participants were unable to identify mental illness from the vignette that was represented to them and this was associated with higher levels negative attitudes towards mental illness. They also noted that the most negative attitudes were shown towards schizophrenia. Further

to these they also reported that those with lower levels of factual knowledge also held more stereotypical beliefs about people with mental illness; many viewed these individuals as violent and unpredictable indicating the impact of lack of factual knowledge on stigma. In support to this referring back to Ozmen et al.'s (2004) study, the results showed that nearly half of the participants perceive those with depression as being dangerous. Considering the other studies done in the field this rate is quite high. For example in Crisp et al.'s (2000) study carryout out in Great Britain 22.9% of the participants associated depression with dangerousness, and in Angermeyer and Matschinger's (2003) this ratio was only 14.2%.

The impact of familiarity on attitudes towards mental illness had also been reported across the world (See Chapter 2). A study conducted by Unnever and Cullen (2009) argued that stigma levels towards mental illness are reduced if the familiarity is increased because familiarity enables greater tolerance consequently leads to a lower levels of stigma. Similarly, Corrigan et al. (2001) conducted a study examining the link between familiarity with mental illness and stigmatisation of someone with a serious mental illness. Students (N=208) were represented with three scales; familiarity, dangerousness, fear and social distance. Results of the pathway analysis suggested that those with higher levels of familiarity reported less negative attitudes related to perception of dangerousness and fear, as well as less desire to be socially distant from someone with a serious mental illness.

Further to these, researchers such as Littlewood (1998) and Kirmayer (2001) stated that culture is particularly important in the field of mental illness as cultural variations may influence the way people identify, understand, express and associate with the mental disorders and their treatments subsequently affecting the stigma associated with such conditions. For example, a study showing the impact of culture on mental illness stigma

was conducted by Mellor, Carne, Shen, McCabe and Wang (2013) with participants from Australia, China and Taiwan. They were asked to complete an attitude scale and a scale assessing cultural values. Results from this study showed that the immigrant Chinese and Taiwanese groups held the most stigmatizing attitudes to mental illness. In addition to this, a significant association between lower stigmatizing attitudes and adaption to Australian culture was found. Australian-born Chinese participants reported less negative attitudes and consequently lower stigma levels compared to Chinese immigrants and Taiwanese participants. Furthermore, Hampton and Sharp's (2014) study showed that compared to Caucasian Americans and Asian Americans Latino Americans held the most stigmatizing attitudes towards mental illness.

5.3 Problem Statement

Although much global research on stigma of mental illness has been carried out (Pinfold, et al., 2003), few studies have been done in Cyprus and only including Greek Cypriots (Papadopoulos 2009; Georgides, 2009). No studies to this date have been carried out on the island comparing the attitudes of the two ethnicities| Turkish and Greek speaking Cypriots who live on the island. This makes it harder to have a clear picture on the attitudes that exist and factors contributing to these levels.

In order to reduce stigma towards mental illness and the negative impact of it on individuals as well as the societies, it is necessary to identify the levels of it as well as the factors that contribute to these levels in either of the communities.

5.4 Research Questions and Hypotheses

- Are there any differences between Turkish and Greek speaking Cypriot societies' attitudes towards mental health problems?
- Due to the previously highlighted differences amongst the two communities (See Chapter 3), their attitudes towards mental health problems are expected to be different. TCs are expected to report less favourable attitudes due to lack of policies and interventions in relation to mental health.
- Where do Turkish and Greek Cypriot societies fit in within the collectivism-individualism cultural dimensions?
- It is hypothesised that both Turkish and Greek Cypriots will fit into the collectivism cultural dimension. TCs will, however, be more collective due to the isolated nature of the society from the outside world (See Chapter 3).
- Do knowledge, familiarity and culture affect the levels of mental illness stigma?
- All these previously highlighted factors are expected to affect the levels of mental health related stigma. It is hypothesised that those with higher levels of knowledge and familiarity with mental health problems will report more favourable attitudes.
- It is also hypothesised the due to the collective cultural values as group dependence and harmony, mental health problems will be viewed more negatively in the TC community.

5.5 Purpose of the Study

The aim of this study was to assess attitudes towards mental illness and the possible factors influencing these attitudes consequently measuring stigma levels in both Turkish and Greek speaking Cypriot communities of Cyprus.

5.6 Research Methods

5.6.1 Participants

One hundred people were recruited for this study using a convenience sampling strategy (See Chapter 4 Section 4.16). Fifty-one of these defined themselves as belonging to the TC cultural group whereas 49 of them defined themselves as belonging to the GC cultural group. The distribution of the age, gender and ethnicity were balanced across the two participant groups (See Table 5.7.1). GC participants were slightly younger as opposed to TCs with an age mean of 26-35 and 36-50 respectively (Please see Table 5.7.1). Most of the participants were university graduates who worked in public services: including teachers, doctors, nurses, bankers and policy makers (Please see Table 5.7.1). Participation to this study was voluntary. They were not known to the researcher and were recruited through mutual contacts using a convenience-sampling strategy.

5.6.2 Materials

Demographic information was obtained from the participants using a demographic questionnaire (See Appendix 4). They were then represented with two vignettes; one which described a man with general life stress (Control Vignette) and the other one that describes a man with schizophrenia. Participants were then asked to rate statements such as 'I think this person has a mental health problem'. Attitudes towards mental illness were then assessed using the Corrigan's 27-Item Attribution Questionnaire (AQ-27). This scale consists of nine sub-scales, which are anger, fear, dangerousness, pity, coercion, responsibility, help, segregation and avoidance (Luty & Varughese, 2010). Participants were given a statement about a person (Harry (GC)/Kemal (TC) with schizophrenia and were then asked to rate their agreements on a Likert type scale from 1 (Completely Disagree) to 9 (Completely Agree) on statements such as '*I would feel aggravated by X'*. All these sub-scales were associated with different aspects of stigma: prejudice, discrimination and ignorance, consequently allowing researcher to investigate the levels of it (See Appendix 7).

Once this was done participants were then given the Level of Familiarity scale, which was developed by Holmes and associates. This was done in order to investigate the participants' levels of familiarity with mental health problems (See Appendix 6). Questions such as *'I have observed, in passing, a person I believe may have had a severe mental illness*' was asked (Corrigan, Canar, Holmes, Kubiak & Williams, 1999). Finally, a shorter version of the culture scale that was developed by Triandis (1993) was used to assess the levels of individualism and collectivism of the participants while also focusing on the vertical-horizontal aspects of it (See Appendix 8). The Vertical-Horizontal Individualism-Collectivism Scale has 16 statements such as 'I would do what would please my family

even if I detested that activity'. The participants responded to the statements on a 4-point Likert type scale ranging from 1 (not at all) to 4 (always).

5.6.3 Design

A mixed model design was used in this study. Ethnicity, familiarity, culture and attitudes being the between subjects factors while knowledge and attitudes were within-subjects factors.

For the between subjects design the dependent variable was attitudes towards mental illness and the independent variables were ethnicity, familiarity and culture.

For the within subjects design the dependent variable was attitudes and the independent variable was knowledge about mental health and illness.

In order to assess the relationship between stigmatizing attitudes and previously identified factors as relating to these attitudes; knowledge, familiarity and culture a cross-sectional correlational design was also used.

5.6.4 Procedure

Prior to the study, questionnaires, consent form, information sheet and the debriefing form were all translated to Turkish and Greek languages. The researcher did the Turkish translation and a native Greek speaker did the Greek translation for the forms. Two independent speakers who were native Turkish and Greek speakers respectively then back

translated these forms to English. Once the agreement was reached on the translation the researcher obtained the ethical approval from Middlesex University of London. The researcher then set up an online survey using e-Survey, which is an online survey, programme commonly used by the researchers. The online survey initially included the information sheet and then the consent form for participants, which asked them to enter their name meaning that they consent to take part in the study. Once they completed filling the consent form they were asked to provide demographic information; age, gender, occupation and education level. They were also asked to provide their contact details; either email address or a phone number as the researcher then aims to carry out interviews with some of the participants. Once these were completed they were represented with two vignettes. One of these was about a man who had a general life stress and the other one was about a man who had schizophrenia. They were then asked to complete a questionnaire assessing their knowledge in regards to these conditions. Upon completion they were represented with another vignette about a person with schizophrenia and were required to complete the AQ-27 in relation to the vignette, which they have previously read. Once they completed AQ-27 they were required to complete the familiarity scale in order to assess how familiar they were with mental health problems. Finally they completed the culture scale developed by Triandis (1993) assessing each of the two societies' cultural structures. They took 15-25 minutes to complete the questionnaires. Upon completion of the scales they were represented with a debriefing sheet which included the researcher's and the supervisory team's contact details and a helpline number in case they wanted to seek help due to the sensitive nature of the research.

5.7 Results

An initial descriptive analysis was carried out to further explore the demographics of the participants (See 5.7.1).

Table 5.7.1

Descriptive Statistics showing the Demographics of TC and GC participants.

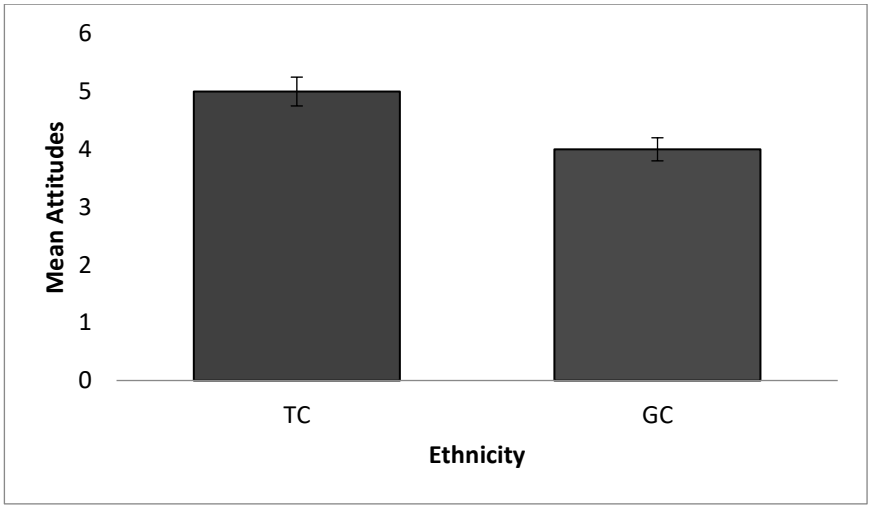
Demographics		TC		GC	
		N	%	N	%
Gender	Male	19	37.7%	22	44.9%
	Female	32	62.7%	27	55.1%
	Teacher	12	23.5%	3	6.1%
Job Category	Public Service	21	41.2%	29	59.2%
	Retired	6	11.8%	1	2.0%
	Unemployed	4	7.8%	4	8.2%
	Student	4	7.8%	3	6.1%
	Media	2	3.9%	2	4.1%
	Health Worker	2	3.9%	7	14.3%
Age (Mean)		36-50		26-35	
	Primary School	3	5.9%	1	2.0%
Education Level	Elementary	2	3.9%	1	2.0%
	High School	14	27.5%	10	20.4%
	Higher Education	32	62.7.4%	37	75.5%

An independent groups t-test was then carried out to assess attitudes towards mental illness. The results showed a significant difference between GC and TC participants in their attitudes; $t(98)=3.98$, $p<0.001$, $\eta p2 = 0.82$, 95% CI [0.17, 0.15]. As Figure 5.7.2 shows TC

report less favorable attitudes towards those with mental health problems compared to GC participants (See Figure 5.7.2).

Figure 5.7.2

Bar Chart showing the differences between the TC and GC participants' Attitudes towards Mental Illness



Once the significant difference was found between the TC and GC participant's attitudes towards mental illness, a further MANOVA analysis was used to compare the means of TC and GC participants on the nine dimensions of mental health related stigma, namely; Anger, Dangerousness, Fear, Threat, Blame, Pity, Help, Coercion, Segregation.

A Multivariate F tests was significant; Hotteling's Trace=1.35, F(23,76)=4.49 p<0.001, η2=0.97. It can, therefore, be suggested that significant differences between the TC and GC participants on the nine dimensions of stigma exist. A multivariate F tests showed that there was a significant difference on the anger dimension of stigma between GC and TC participants; F (1, 98)= 9.66, p=0.002, η2=0.09. GC participants reported significantly lower levels of anger towards those with mental illness (See table 5.7.3). There was also a significant difference between TC and GC participants on the Dangerousness dimension of stigma; F (1, 98)=3.92, p=0.05, η2=0.04. TC participants reported significantly higher perceptions of dangerousness (See Table 5.7.3).

Significant differences were also found in regards to the Fear dimension of stigma; F (1, 98)=8.14, p=0.005, η2=0.77. GC participants also reported lower levels of Threat perceptions. Further to these they differed significantly on the Avoidance dimension of stigma as well; F (1, 98)=30.487, p<0.001, η2=0.23. TCs reported more desire to be socially distant from those who have mental illness (See Table 5.7.3). Significant differences were further observed in relation to the Help dimension; F (1, 98)=12.24, p=0.001, η2=0.11 and Blame F (1, 98)=3.98, p=0.04, η2=0.04 dimensions of stigma (See Table 5.7.3). TCs were less likely to help individuals with mental illness and more likely to attribute blame on them. Further to these TC and GC participants also differed in regards to the Pity dimension; F (1, 98)=2.54, p=0.05, η2=0.03, Coercion F (1, 98)=4.92, p=0.02, η2=0.02 and Segregation F (1, 98)=3.42, p=0.05, η2=0.07 dimensions of stigma. GCs were more likely to report feelings of Pity compared to the TCs. They were also less likely to support coercive treatment of mental illness and segregation of people with mental illness (See Table 5.7.3).

Table 5.7.3

Descriptive Statistics Table Showing the difference between TC and GC on the dimensions of Mental Health Related Stigma (N=100)

	Ethnicity	Mean	Std. Deviation
Anger	TC	7.00	3.38
	GC	4.94	3.24
Dangerousness	TC	13.10	5.24
	GC	10.86	6.06
Fear	TC	13.78	6.47
	GC	10.27	5.83
Coercion	TC	19.47	4.66
	GC	18.00	4.84
Segregation	TC	15.78	6.03
	GC	12.96	3.82
Avoidance	TC	13.75	3.84
	GC	9.16	4.45
Help	TC	8.73	4.22
	GC	5.98	3.59
Pity	TC	10.57	4.58

	GC	12.16	3.39
Blame	TC	13.78	5.23
	GC	11.71	5.11

In regards to knowledge on mental health there was not a significant difference between TCs and GCs for the control condition; $t(98)=0.04$, $p=0.96$, $\eta 2 = 0.12$, 95% CI [-0.22, 0.22]. There was, however, a significant difference between GCs' and TCs' knowledge about schizophrenia; $t(98)=-2.38$, $p=0.02$, $\eta 2 = 0.47$, 95% CI [-0.38, -0.34]. GC participants reported being more literate in regards to mental illness. A more detailed Multivariate analysis showed a non-significant difference between TC and GC participants in regards to the identification of illness, $F(1, 98)=0.32$, $p=0.58$, $\eta 2=0.003$. There was also

not a significant difference between GC and TC in regards condition recognition; $F(1, 98)=0.22$, $p=0.88$, $\eta 2=0.001$.

They, however, significantly differed in their perception of the treatment; There was also significant differences in regards to the recommendations of seeking Professional Help; $F(1, 98)=5.22$, $p=0.024$, $\eta 2=0.05$, treatment of the condition $F(1, 98)=54.34$, $p<0.001$, $\eta 2=0.36$ and Advice; $F(1, 98)=115.67$, $p<0.001$, $\eta 2=0.54$. Majority of the TC participants (52.9%) suggested the treatment of schizophrenia "not being hard" as opposed to majority of the GCs (95.9%) who suggested the illness being "very hard" to treat. It was also found that Majority of the TCs were less likely to advise seeking professional help and significantly endorsed self-reliance (76.5%) more compared to GCs who endorsed importance of seeking professional help more (95.9%) (See Table 5.7.4).

Table 5.7.4

Descriptive Statistics Showing the Difference between GC and TC Participants Knowledge on Mental Illness (N=100)

	Ethnicity	Mean	Std. Deviation
Mental Illness Identification	TC	1.18	.518
	GC	1.12	.439
Condition Recognition	TC	3.31	1.631
	GC	3.27	1.643
Factors Causing the Condition	TC	3.45	1.222
	GC	3.18	1.453
Professional Help	TC	1.02	.140
	GC	2.16	.426
Treatment of the Condition	TC	1.20	.633
	GC	2.94	.317
Advice	TC	1.24	.428
	GC	2.96	.200

Further to these, GCs and TCs significantly differed in their familiarity with mental health problems; $t(98)=-4.654$, $p<0.001$, $\eta p2=.876$, CI [-0.263, -1.033]. GCs were significantly more familiar with mental health problems compared to TCs.

In addition to these cultural differences found amongst the participants, TCs were significantly more vertical collectivist when compared to GCs; $t(98)=3.265$, $p=0.002$ $\eta2=.098$, CI [0.323, 1.324]. Furthermore, GCs were significantly more horizontal individualist as opposed to TCs; $t(98)=-2.375$, $p=0.02$ $\eta2=.054$ CI [-1.433, -.1032].

A Partial Correlation Analysis was then carried out to assess relationship between mental health related attitudes and three previously highlighted factors namely; knowledge, familiarity and culture while controlling for the demographic factors; age, sex, educational and employment status. The correlation between knowledge and mental health related attitudes was significant; ($r(98)=-0.25$, $p=0.04$). It was suspected that sex, age, educational and employment status might explain this relationship. Upon controlling for these variables, however, mental health related attitudes were still found to be related to knowledge, $r(98)=-0.03$, $p=0.04$. Thus, even after controlling for the demographic variables, those who reported higher levels of knowledge about mental health also reported more favorable attitudes towards people with mental illness.

The correlation between familiarity and mental health related attitudes was also found to be significant; ($r(98)=-0.42$, $p=0.001$). It was suspected that the aforementioned demographic variables might explain this relationship. Upon controlling for these variables, however, mental health related attitudes were still related to familiarity, $r=-0.21$, $p=0.04$. Thus, even after controlling for the demographic variables, participants with higher levels of familiarity reported more favorable attitudes towards people with mental illness.

The correlation between collectivism and mental health related attitudes was significant; $r (98)=0.14$, $p=0.02$). After controlling for the demographic variables this relationship was still significant; $r (98)=-0.01$, $p=0.03$. A detailed analyses on the dimensions of collectivism; vertical and horizontal showed a significant relationship between vertical collectivism and mental health related attitudes; ($r(98)=0.21$, $p=0.04$) . After controlling for the demographic variables this relationship was still found to be significant; $r(98)=0.27$, $p=0.008$. Thus, even after controlling for the demographic

variables, those who reported being vertical collectivist also report edless favorable attitudes towards people with mental illness. Relationship between horizontal collectivism and mental health related attitudes was, however not significant (r (98)= 0.32, p=0.12).

Finally The correlation between individualism and mental health related attitudes was also found to be non-significant; r (98)=-0.36, p=0.7. Thus suggesting no relationship between attitudes and individualism.

5.8 Discussion

As expected the results of this study showed that TC participants reported less tolerant attitudes towards mental illness. Relative to the previous research on knowledge, familiarity, culture and mental health related attitudes (Evans-Lacko, Henderson & Thornicroft, 2013; Stier & Hinshaw, 2007; Zartaloudi & Madianos, 2010; Papadapoulos, 2009 & Cheon, 2012), results of this study had also identified these as contributing factors to the stigma of mental illness in the two communities of Cyprus.

The findings of this research showed that those with lower levels of mental health literacy reported higher levels of negative attitudes. Parallel with this a study carried out by Reddy, Foster, Asbury and Brooks (2011), also reported that increase in knowledge leads to reduction of negative attitudes consequently lower levels of mental illness stigma. In this study GCs reported higher levels of knowledge and it is likely that the recent anti stigma campaigns had an impact on the public's level of mental health literacy. This is believed to be related with more tolerant attitudes towards mental illness. In support to this a study carried out by Manisch et al. (2016) also looked at the effectiveness of the anti stigma campaigns on increasing knowledge about and attitudes towards mental illness at work

place. They carried out a literature search reviewing 16 journal articles that consisted of 3,854 participants in total. Interventions used in these studies mainly used mental health literacy programs that aim to increase factual knowledge. Results showed that ten anti-stigma interventions were effective in increasing mental health knowledge. Others, such as Svenson and Hanson (2014) as well as Jorm (2010), had supported the finding of this study further. These studies along with the finding of the current study suggests that anti-stigma programs used with the public are effective in increasing their knowledge which is likely to lead to more favorable attitudes towards mental illness. It may, therefore, be argued that lack of these interventions within the TC community is likely to have resulted in majority of the participants being unable to recognize the illness and offer appropriate treatment for it.

Another finding of this study was that GC participants reported significantly more familiarity with mental illness compared to TCs. As well as knowledge familiarity with mental illness had been linked to positive attitudes by previous research (See Chapter 2). Previous work done in the field suggests that familiarity with mental health problems tends reduce one's desire to be socially distant from individuals with mental health problems as well as their attitudes as it increases understanding and helps placed misperceptions about mental illness with facts (Corrigan, et al., 2001). Parallel with this Sampugna et al.'s (2016) study that assessed the efficacy of Time to Change anti-stigma programme on attitudes between 2009 and 2014 also reported the importance of familiarity on reducing stigma towards mental illness. As mentioned in Chapter 2 familiarity with mental illness can be gained through media or one to one contact. Previous work done in the field commonly reports that the latter one is more effective in reducing attitudes due to irresponsible media

coverage about mental illness across the world (See Chapter 2). Time to Change programme used both social marketing campaign as well as social contact that allowed public to come in contact with those who have mental illness. In their study Sampugna et al. (2016) interviewed 10,526 participants using an online knowledge [Mental Health Knowledge Schedule (MAKS)]; attitudes [Community Attitudes toward Mental Illness (CAMI)]; and behaviours (Reported and Intended Behaviour Scale (RIBS) scales. Results of this study showed that the usage of the social media channels and an increased participation to social contact events organised by the Time to Change program significantly increased knowledge as well as the tolerance and support on the subscales of the CAMI scale. These findings suggest that when media is used responsibly it could be an effective tool in increasing knowledge about and familiarity with mental illness but also in changing attitudes. Further to these, such interventions seem to be effective in increasing tolerance and support shown to individuals with mental illness. This supports the findings of this research, which showed that TCs who reported significantly lower levels of familiarity with mental illness compared to GCs, also significantly supported statements about the segregation of individuals with mental illness. Such statements were related to discrimination of individuals from the society consequently discrimination of them (See Appendix 7). It could be argued that by increasing tolerance and support given to individuals it may be possible to reduce support given to segregation of individuals with mental illness which in turn will help them integrate within their communities consequently increasing their quality of lives.

Further to this as expected another factor that played a significant role on attitudes was culture. Although both communities scored high in collectivism, TCs were found to be

significantly more vertical collectivist. As mentioned in Chapter 2 vertical collectivism is associated with 'hierarchy' where power, status, and conformity to the cultural norms and values are very important (Triandis, 1993). GCs, on the other hand, were found to be significantly more horizontal individualist in this study. Horizontal individualism is associated with individuals having equal status, independence and being self-driven (Singelis, 1995). These results were surprising for the researcher, as she did not expect GC participants to report as high levels of individualism as it was found in this study. This is because although in Greek culture independence and individuality is emphasized previous research suggested a strong link between family members as well as loyalty to in-group members (Broome, 1996).

This unexpected result could, however, be due to the recent changes within the GC communities. For example it could be suggested that after joining the European Union (EU) GCs had more chance to open to the world in different arenas; social, political as well as economical. Globalization or the increase interconnectedness may also be influencing the cultural structure of the GC society as they now have more interaction with other cultures, particularly those from Europe. It could, therefore, be suggested that the dependence amongst the GC community members may have been loosen since the joining of European Union in 2004.

Unlike the Republic of Cyprus, the self-claimed Turkish Republic of Northern Cyprus still remains as an un-recognized state. It is only recognized by Turkey and, therefore, TCs live in isolation economically, politically and humanitarianly (Kanol, 2017). Efforts were made to reduce the isolation of TC community by the EU Council as well as the United Nations. The United Nations Secretary at the time of GC joining EU-General

Kofi Annan stated in his report that *"to eliminate unnecessary restrictions and barriers that have the effect of isolating the Turkish Cypriots and impeding their development, deeming such a move as consistent with Security Council re solutions 541(1983) and 550(1984)"* (Reports of the Secretary General (2004, p. 93). This was, however, not achieved and up to this date TCs still carry on living in complete isolation. Due to this the state members of the TRNC tend to rely on each other to get things done, as they have limited contact with the outer world. This might have increased their reliance to their in-group members consequently increasing the collective nature of the community (Hofstede, 2001).

In addition to this traditionally Cypriot society as a whole is accepted as having a hierarchal nature (See Chapter 2). One can see the existence of hierarchal system throughout the island's history. For example during the Ottoman Empire in 1570s the most powerful status was given to sultan, next in line was grand viziers, followed by viziers and messieurs (Kose, 2017). With the occupation of the island by Turkey since 1974 this hierarchal system had continued and this is reflected not only in the political arena but also in the community's daily interactions. For example TCs tend to use more hierarchal words as plural form of you 'siz' when talking to others instead of the singular form 'sen'. Within the TC culture the plural form 'siz' is mainly used to talk to those who are elderly or in power prior to Turkish invasion of the island. With the increased societal change in the TC community such changes within the dialect that reflects the hierarchal nature of the community also took place over the years (Bryant & Yakinthou, 2012). Unlike the TC community, it can be suggested that the system had shifted towards becoming more liberal for the GC community after joining the EU particularly after adopting equal treatment and anti discrimination laws in line with EU: Equal Treatment in Employment and Work

(Racial or Ethnic); Equal Treatment in Employment and Occupation 59; Person with Disabilities Law and Fighting racial and other Discriminations.

In parallel with the findings of this study, previous studies noted the positive relationship between stigma and vertical collectivism. For example a study conducted by Liu, et al. (2011) in China assed the attitudes towards homosexual men. They found that those who reported a vertical collectivist cultural orientation also reported higher levels of stigma. Considering the orientations of the vertical collectivist societies that are importance given to the authority figures and to the obedience to the norms established by those who are in power (Triandis, 2001) higher levels of stigma would be expected to conditions as having a mental illness or being homosexual. This may be because such conditions could be perceived as not acceptable by the authority figures and in line with the norms and traditions of the culture, consequently increasing the levels of stigma towards such individuals in societies that are more vertical collectivist (Liu, et al., 2011). Studies carried out on the link between the horizontal individualist dimension of culture and stigma, however, showed an inverse relationship between this orientation and negative attitudes. This may be due to the fact that individuals from these cultures mainly prioritised self-interest and act more independently from their groups (Ho & Chie, 1994). It could also be argued that GC participants may be less likely than the TC ones to perceive mental illness as a condition that negates or abdicate their status or authority, mainly due to the emphasis put on the equality of the society members within the horizontally oriented communities (Triandis, 1995). This might have also be reflected in TC and GCs' attitudes towards mental illness.

Further to the findings of this study it could be explained using a psychosocial

framework (See Figure 5.2.1). According to this model individuals have experiences that include culture, familiarity and labelling which influences their perception about mental illness and those with mental illness. This then helps form affect leading to emotional responses such as fear, anger and pity. In this study, the more collective structure of the TC community combined with lack of knowledge and familiarity with mental health problems (experience) resulted in higher perception of dangerousness, which in turn resulted in more anger, fear and lower pity (affect). This has led to increased avoidance and discrimination of those with mental illness (behavioural response).

5.9 Study Limitations

Although this study brings recent information to the field about mental illness stigma considering it's the first comparison study ever to be conducted in Cyprus, it does have some limitations. It should be noted that a more balanced sample in regards to the demographic characteristics is needed. This is because compared to the Southern Cypriots, Northern Cypriots were slightly older and previous studies have found a link between age and stigmatizing attitudes towards mental illness; the older generation reporting higher levels of stigma compared to the younger generation (Niwako, et al. 2011). In addition to this, most of the participants were educated to a higher degree level. Although a partial correlation analysis was carried out it is suggested for the future studies to recruit more balanced samples in relation to education levels. This is because according to some researchers higher levels of education lead to higher tolerance towards mental illness consequently reduction in negative attitudes (Girma, et al., 2014; Hannigan, 1999). Future research should, therefore, match participants in regards to their socio-economic status. Finally, it should also be noted that the vignette used in this study for the attitude scale was

about a person with schizophrenia, future research should focus on other mental health conditions as well in order to be able to get a better understanding of the attitudes towards different mental health problems. Despite these limitations, the findings of this study provide a valuable understanding of the stigmatization of mental illness in Cyprus. It also gives insight to public's beliefs about mental illness and allows researchers for future development of interventions to reduce stigma

5.10 Conclusion

In conclusion, the pilot study has shown that the study was feasible as it ensured that the questions were understandable in the participants' native languages and the questionnaires were giving acceptable reliability levels. As stated at the beginning of this chapter the pilot study also allowed the researcher to get an overview of the public stigma towards mental illness in the two communities. The negative attitudes were existent in the both Turkish and Greek speaking Cypriot communities. Participants from the both communities were, however, found to be endorsing negative statements at differing levels. This was due to the differences found between them in regards to knowledge, culture and familiarity.

Chapter 6- Main Quantitative Study Chapter

6.1 Introduction

This chapter aims to provide detailed explanations to the findings of the main quantitative study. For this purpose the researcher will begin with the explanations of the aims and hypotheses along with the rationale for this study. The researcher will then explain the methodology that she employed for this part of the project. Finally the results of this study will be reported and a detailed discussion of the results will be provided at the end of this chapter.

6.2 Rationale, Aim and Hypotheses of the Study

The Pilot study aimed to compare the two ethnic groups of Cyprus in regards to their attitudes towards mental illness. It, therefore, brings valuable information on the stigma of mental illness in Cyprus. As mentioned in the previous chapter it was, however, a small scaled study that only included 100 participants. The aim of this study was, therefore, to assess attitudes of Greek and Turkish speaking Cypriots towards mental health problems. The researcher also aimed to examine the similarities and differences between the two communities in regards to their mental health literacy, familiarity with mental health problems as well as the cultural structures. The relationship between these factors and attitudes was also examined in this study. Further to these the researcher also aimed to construct a comprehensive set of dimensions that reflect stigma towards mental health problems, and to examine the factor structure and reliability of these dimensions.

Following the previous research done in different societies around the world with different ethnic and cultural groups in regards to stigma of mental illness (See Chapter 2) the researcher hypothesised that greater mental health literacy and familiarity with mental health problems and lower levels of collectivism will contribute to less negative attitudes, therefore, stigma towards mental illness. It was also hypothesized that due to the recent policy changes in regards to mental health and well being and the establishment of the anti-discriminatory law in the Republic of Cyprus (See Chapters 2 & 5), GCs will have higher levels of knowledge/mental health literacy, familiarity. Further to these it was also hypothesised that TCs will score higher on the collectivism dimension of culture because of the isolated and the unrecognised nature of the community (See Chapters 3 & 5). It is, therefore, hypothesised that GCs will report less negative attitudes, and, lower levels of stigma towards mental illness compared to TCs.

6.3 Methodology

6.3.1 Participants

Researcher recruited 519 participants via the use of a convenience sampling strategy for this study. In order to assess potential confounding demographic variables preliminary cross-tabulation analyses were carried out on the demographic information gathered from the Turkish and Greek Cypriots in order to assess if there were any significant differences between them. Age range of the participants was 18 to 85. There was not a significant difference between Turkish and Greek Cypriots in their age ($\chi^2(3)=5.089$, $p=0.165$). Out of 519 participants 380 of them were professionals including medical doctors, teachers and bankers. 139 of them were non-professionals including students, unemployed and retired.

Similarly there was not a significant difference between Turkish and Greek Cypriots' employment status ($\chi^2(1)=1.558$, $p=0.212$). Highest education level of the participants also ranged from Primary School to University level. There was also not a significant difference between Turkish and Greek Cypriots' education levels ($\chi^2(2)=4.741$, $p=0.093$). Finally, there was also not a significant sex differences between Greek and Turkish Cypriots ($\chi^2(1)=1.489$, $p=0.222$).

Participation to this study was voluntary and they were not known to the researcher and were recruited through mutual contacts. Participants were informed that they could withdraw from the study at any time that they want without providing any reason. Confidentiality of the participants was also ensured via the use of pseudonyms.

6.3.2 Materials

The same questionnaires from the Pilot study were used in this study (see Chapter 5 for more details). It should, however, be noted that three questions were omitted from the AQ-27 questionnaire for this research. This was because during the pilot study participants reported that two of the questions were found to be a repetition: For example question 20 asked participants *'How likely is it that you would help X?' and question 21 was 'How certain would you feel that you would help X?'* In this case researcher decided to keep question 20 and exclude question 21 from the questionnaire. Further to these one of the questions, which asked participants whether they would, car pool with the person in the vignette was not understood by the participants, as the concept car-pooling is not common in either of the Cypriot communities. For this reason it was decided to exclude these

questions from the scale for the purpose of this study. No changes to the other questionnaires were made.

6.3.3 Design

An exploratory cross-sectional survey design was implemented in the study, and both descriptive and inferential analyses were conducted on the data. The dependent variable was attitudes towards mental illness and the independent variables were knowledge, familiarity and culture.

6.3.4 Procedure

Prior to the study, the questionnaires, consent form, information sheet and debriefing form were translated to Turkish by the researcher, to Greek by a Greek speaker and back-translated to English by an independent Turkish and Greek native speakers. Once the agreement was reached on the translation the researcher obtained the ethical approval from Middlesex University of London. Once the ethical approval was obtained researcher travelled to Cyprus and collected data for one month. Participants were recruited in small groups that consisted maximum of 30 people at once. Participation took place in either participant's houses or in the facility rooms provided by different organizations that the researcher had contacted for the purpose of data collection. Upon arrival to the agreed location participants were first given the information sheet (See Appendix 1) and then the consent form for participants, which asked them to enter their name meaning that they consent to take part in the study (See Appendix 2). Once they completed filling the consent form they were asked to provide demographic information; age, sex, occupation and education level (See Appendix 3). They were also asked to provide their contact details;

either email address or a phone number as the researcher then aims to carry out interviews with some of the participants. Once these were completed they were represented with two vignettes. One of these was about a man who had general life stress and the other one was about a man who had schizophrenia (See Appendix 4). They were then asked to complete a questionnaire assessing their knowledge in regards to these conditions. They then were represented with another vignette about a guy with schizophrenia and were required to complete the AQ-27 in relation to the vignette, which they have previously read (See Appendix 4). Once them completed AQ-27 they were required to complete the familiarity scale in order to assess how familiar they were with mental health problems (See Appendix 5). Finally they completed the culture scale developed by Triandis (1993) assessing each of the two societies' cultural structures (See Appendix 6). They took 15-25 minutes to complete the questionnaires. Upon completion of the scales they were represented with a debriefing sheet which included the researcher's and the supervisory team's contact details and a helpline contact number in case they wanted to seek help as the nature of the research was sensitive (See Appendix 7).

6.4 Results

The aim of the results section is to narrate the findings of the quantitative part of this thesis. Initially the researcher carried out Correlational Analyses in order to assess the relationship between the dependent variable; attitudes towards mental illness and the independent variables; knowledge, familiarity and culture. The researcher then carried out an Independent Sample t-test to compare the two ethnic groups in regards to their knowledge and familiarity with mental health, differences in regards to the cultural structure of the Turkish and Greek Cypriot communities and attitudes towards mental

illness. This was then followed with a Horn's Parallel Analysis (PA), which aimed to assess the factorability of the AQ scale. Once the factorability of the AQ questionnaire was assessed and the main predictors of mental health related stigma were extracted researcher carried out a three-step Hierarchal Regression analysis to test the effects of the each predictor variable independently on the dimensions of stigma.

6.4.1 Correlational Analysis

A strong negative significant correlation was found between Negative Attitudes and Ethnicity; this indicating that GCs are less likely to report negative attitudes towards mentally ill compared to TCs (See Table 6.4.1.1). There was also a strong significant positive relationship between ethnicity and familiarity (See Table 6.4.1.1); compared to TCs, GCs were more familiar with mental health problems. A strong negative relationship was found between Familiarity and Negative Attitudes (See Table 6.4.1.1); as familiarity increased negative attitudes were lessened. No relationship was found between negative attitudes and knowledge (See Table 6.4.1.1); knowledge did not seem to be relating to negative attitudes.

A moderate negative relationship was found between horizontal individualism and attitudes and a negative weak relationship was found between vertical individualism and negative attitudes (See Table 6.4.1.1). Thus suggesting that as horizontal and vertical individualism increased negative attitudes were lessened. Furthermore, a significant positive relationship was found between horizontal collectivism and negative attitudes (See Table 6.4.1.1). Finally, a moderate significant positive relationship was also found between

vertical collectivism and negative attitudes (See Table 6.4.1.1). Thus suggesting as horizontal and vertical collectivism increased negative attitudes also increased.

Table 6.4.1.1

Correlations Among and Descriptive Statistics for Key Study Variables (N = 514)

	M	SD	1	2	3	4	5	6	7
Ethnicity	1.49	0.50	1						
Attitude	5.00	1.65	-0.70***	1					
Familiarity	1.36	0.24	0.63***	-0.76***	1				
Knowledge	2.17	0.37	0.004	0.06	-0.33	1			
HI	6.66	1.63	0.33***	-0.30***	0.30***	-0.08	1		
VI	5.44	1.77	0.18***	-0.19***	0.18***	0.02	0.24***	1	
HC	6.53	2.20	-0.26***	0.17***	-0.16***	0.03	0.02	-0.05	1
VC	7.40	1.29	-0.30***	0.37***	-0.28***	-0.02	0.02	-0.41***	0.30***

*Note. Statistical significance: (Note. Statistical significance: *p < .05; **p < .01; ***p < .001.)*

6.4.2 Independent Sample T-Test

Further to the correlational analyses an independent sample t-test was carried out in order to assess the differences between Turkish and Greek Cypriot participants in regards to their knowledge on mental health problems, familiarity, culture and attitudes.

Results showed that there was not a significant difference between the two ethnic groups on their knowledge about mental health when represented with a control vignette; $t(517)=-0.693$, $p=0.49$, $\eta 2=0.132$, 95% CI [-0.125 0.057]. There was also no significant difference found between them on their knowledge about mental illness; $t(517)=0.082$, $p=0.934$, $\eta 2=0.154$, 95% CI [-0.076 0.066]. There was, however, a significant difference

between Turkish and Greek Cypriots in their familiarity with mental health problems; t(517)=-18.46, p<0.001, η2=0.867, 95% CI [-0.342 -0.283]. GCs were found to be significantly more familiar with mental health problems compared to TCs.

There were also significant cultural differences between the two communities. GCs were significantly more individualist; t(517)=-7.542, p<0.001, η2=0.644, 95% CI[-1.063 -0.623]. TCs, on the other hand, reported to be significantly more collectivist; t(517)=8.593, p<0.001, η2=0.742, 95% CI[0.743 1.185]. Further detailed analysis on the vertical horizontal dimensions also revealed significant differences amongst the two ethnic groups. While GCs were significantly more horizontal t(517)=-7.821, p<0.001, η2=0.745, 95% CI[-1.324 -0.798] and vertical individualist; t(507)=-4.095, p<0.001, η2=0.463, 95% CI[-0.933 -0.334], TCs were found to be significantly more horizontal t(507)=6.186, p<0.001, η2=0.544, 95% CI[0.463 0.893] and vertical collectivists t(507)=7.454, p<0.001, η2=0.623, 95% CI[-1.061 -0.621]. Finally there were significant differences on the Attitudes of TCs and GCs towards mental illness; t(507)=22.413, p<0.001, η2=0.866, 95% CI[2.123 2.524]. TCs reported significantly higher negative attitudes towards mentally ill compared to GCs

6.4.3 Horn's Parallel Analysis (PA) & Principal Component Analysis on AQ-27

After the independent groups t-tests were carried out the researcher conducted a Principal Component Analysis (PCA). The PCA is believed to be an efficient way to explain variance amongst a large number of variables by using much smaller dimensions that are called latent factors. Further to this a rationale for carrying out PCA on the AQ-27 was that the researcher felt that some of the variables in AQ-27 scale measured the same stigma related constructs as anger. She, therefore, wanted to carry out a PCA in order to be able to extract dimensions that most closely represent the attitudes towards mental illness.

As a result the researcher was able to reduce the nine dimensions of the stigma that were initially introduced by Corrigan et al. (2001); responsibility (people with mental illness can control their symptoms and are responsible for having the illness), pity (people with mental illness are overtaken by their own disorder and therefore deserve concern and pity), anger (people with mental illness are blamed for having the illness and provoke wrath and rage), dangerousness (people with mental illness are not safe), fear (people with mental illness are dangerous), help (people with mental illness need assistance), coercion (people with mental illness have to participate in treatment management), segregation (people with mental illness are sent to institutions located far from the community), and avoidance (patients with mental illness do not live in society). As a result nine dimensions were consequently reduced to four; Threat, Perceived Control, Pity and Hospitalization (See Table 6.4.3.1).

Table 6.4.3.1

Factor loadings and communalities based on a principal components analysis with an Orthogonal rotation for the 22 items from the AQ-27 Attitude Scale (N = 519)

	Threat	**Blame**	**Pity**	**Hospitalisation**	**Communalities**
I would feel aggravated by X.	0.84				0.80
I would feel unsafe around X	0.83				0.80
X would terrify me.	0.83				0.78
How angry would you feel at X?	0.77				0.70
How irritated would you feel by X?	0.78				0.73
How dangerous would you feel X is?	0.79				0.70
How likely is it that you would help X?	-0.57				0.55
I would be willing to talk to X about his problems.	-0.68				0.65
If I were an employer I would interview X for a job.	-0.64				0.56
If I were a landlord I would rent an apartment to X.	-0.66				0.59
I would feel threatened by X.	0.78				0.70
How scared of X would you feel?	0.79				0.70
I would think it was X's own fault that he is in the present condition		0.85			0.89
How controllable do you think is the cause of X's present condition?		0.82			0.82
How responsible do you think is X for his present condition?		0.80			0.81
I would feel pity for X.			0.80		0.66

How much sympathy would you feel for X?	0.84		0.79
How much concern would you feel for X?	0.77		0.75
I think it would be best for X's community if he were put away in a psychiatric hospital.		0.72	0.59
How much do you think an asylum, where X can be kept away from his neighbours is the best place for him.		0.80	0.65

Prior to PCA she carried out a Horn's Parallel Analysis (PA) method for determining the number of factors in a Principal Components analysis (PCA) as researcher believed this to be more appropriate than relying on the less scientific Scree plot method (Leedsma & Valero-Mora, 1999; see Hayton, Allen, & Scarpello, 2004) for instruction and further justification. An initial run revealed an orthogonal four-factor solution. This was followed by a series of runs resulting in 21 of the 24 items with communalities greater than 0.3 included in the final analysis. The Kaiser-Meyer-Olkin measure of sampling adequacy was 0.923 (above the recommended value of 0.6) and Bartlett's Test of Sphericity was significant (χ^2 (210) = 8450.31, $p < .001$). Individually, the amount of variance accounted for by the factors after the rotation were: 47.93%, 8.392%, 8.01% and 6.03%. Items from the questionnaires and the corresponding factor loadings are presented in table 6.4.3.1. The correlations between the factors ranged from -0.57 to 0.85.

When interpreting the rotated factor pattern an item was said to load on a given component if the factor loading was .40 or greater for that component and did not have equivalent, salient loading on more than one factor. Using these criteria all the 21 items were interpreted. Twelve items were found to be loading on the first component, which consisted items regarding feelings and reactions. This was labeled as Threat. Furthermore, three items were found to be loading on the second component which was concerned with responsibility and control, this was labeled as Blame. The third component had three items about concern and pity loading on it and which was labeled as Pity. Finally two items

regarding the treatment were found to be loading on the fourth and final component that was labeled as Hospitalisation.

In order to assess the internal consistency of the empirically-derived AQ subscales, Cronbach's α was carried out for the total score and subscale scores generated from the items with primary salient loadings on each factor (Items 5, 14, 22 were excluded). The Threat subscale (12 items) reported an excellent reliability; α=0.94. For the Blame subscale (3 Items) this was α=0.91, for the Pity subscale (3 items) α=0.83 and for the final Hospitalisation subscale (2 Items) α=0.64 (Barbaranelli, Lee, Vellone, Riegel, 2015). A correlational analysis was also carried out for the two items loading in Hospitalisation subscale. There was a positive large correlation between them that was significant; r=0.48, p<0.001. The data scores also suggest an approximate normal distribution making it suitable for further parametric statistical analyses. Scores were computed for the new factors using the Anderson-Rubens procedure in SPSS.

Table 6.4.3.2

Descriptive statistics for the four scale Attitude Scale Factors (N=519)[1]

	No. of items	Skewness	Kurtosis
Threat	13	-.15	-.78
Perceived Control	3	.21	-.55
Pity	3	.31	-.74
Hospitalisation	2	-.33	.13

Hayton, J.C., Allen, D.G. & Scarpello, V. (2004). Factor retention decisions in exploratory factor analysis: a tutorial on parallel analysis. Organizational Research Methods, 7, 191-205.

[1] Note Anderson-Rubens scores are mean=0, SD=1 and fully orthogonalised.

6.4.4 Three-Stage Hierarchal Regression

Once the four dimensions of stigma were constructed using the PCA the researcher came up with a model that consisted of factors, which she believed, predict the four-constructed dimensions of mental illness stigma. In order to test the model she carried out a three-step Hierarchal Regression.

The hypotheses were that:

1. Demographic factors will predict the, Threat, Perceived Control, Pity, and Hospitalization dimensions of mental health related stigma.

2. Demographic, Mental Health Literacy/Knowledge, Familiarity, Culture factors will predict Threat, Perceived Control, Pity, and Hospitalization dimensions of mental health related stigma.

3. Mental Health Literacy/Knowledge and Familiarity and Culture will predict the four-dimensions of stigma.

4. Mental Health Literacy/Knowledge will uniquely predict four dimensions of stigma.

5. Familiarity with mental illness will uniquely predict four dimensions of stigma.

6. Culture will uniquely predict four dimensions of stigma.

Before conducting a hierarchical multiple regression the necessary assumptions in relation to this analysis were tested. A sample size of 514 was considered to be appropriate in the case of having 11 predictor variables in the analysis (Tabachnick & Fidell, 2001). The singularity assumption was also satisfied as the independent variables (Highest Education Level, Sex, Age, Employment, Knowledge, Familiarity, Ethnicity, Vertical Individualism, Horizontal Individualism, Vertical Collectivism, Horizontal Collectivism), were not a combination of other independent variables. Furthermore, a correlational analysis revealed that none of the variables were highly correlated with each other, therefore, the assumption of multi-collineartiy was met (Coakes, 2005; Hair et al., 1998). In addition to these assumptions of normality, linearity and homoscedasticity were all met as Scatter plots showed (Hair et al., 1998; Pallant, 2001).

A three-stage hierarchical multiple regression was then conducted in order to assess if the demographic, attitudinal and culture variables can explain a significant amount of variance of the dependent variable; negative attitudes. As the results of the pilot study also suggested (See Chapter 5), previous research also argued that the demographic factors as age, gender, educational level and employment can have an impact on public's attitudes towards mental illness (Lauber, Nordt, Falcato & Rossler, 2004). For this reason the demographic factors were entered at stage one of the hierarchical multiple regression. Attitudinal variables, which are knowledge and familiarity, were also reported by the previous research as influencing attitudes towards mental illness (Papadopoulos, 2009). For this reason these factors were entered to the model at stage two. Finally as stigma is a social construct previous research also suggests that one's ethnicity and cultural orientation are important factors that may be influencing attitudes towards mental illness. These factors

were, therefore, entered to the model at stage three.

With the *'Threat'* dimension being the target variable the demographic variables (highest education level, age, sex and employment) were entered at stage one. The attitudinal variables (Familiarity and Knowledge) were entered at stage 2. Finally, the ethnic and cultural variables (Ethnicity, Horizontal-Vertical Collectivism/Individualism) were entered in to the model at stage three. Inter-correlations amongst the variables are shown in Table 6.4.4.1 and the regression statistics are being shown in 6.4.4.2.

Table 6.4.4.1

Correlations Among and Descriptive Statistics for the Threat Dimension (N = 514)

	M	SD	1	2	3	4	5	6	7	8	9	10	11	12
Threat(1)	0	1												
Sex(2)	1.61	0.50	.09											
Age(3)	2.48	1.09	.04	-.24										
Employment(4)	1.59	0.80	-.01	.08	-.30									
Education Level(5)	2.64	0.56	.001	-.04	.05	-.32								
Familiarity(6)	1.34	0.24	-.61	-.03	.04	-.08	.10							
Knowledge (7)	2.18	0.38	.07	-.02	-.08	-.03	.02	-.33						
Ethnicity(8)	1.49	0.50	-.54	-.05	-.08	-.06	.08	0.63	.04					
HI (9)	6.67	1.53	-.33	.05	.01	.02	.01	.30	-.08	.33				
VI (10)	5.44	1.78	-.16	.03	-.03	-.03	.02	.18	.02	.18	.24			
HC(11)	7.40	1.29	.87	.07	.08	-.08	.02	-.16	.03	-.26	.02	-.05		
VC (12)	6.53	2.23	.23	.04	.02	.01	-.06	-.28	-.23	-.30	.02	-.41	.30	

Note. Statistical significance: ($p < .05$; ± $r=0.13$, $p < .01$; $p < .001$, ± $r=0.092$)

Table 6.4.4.2

Summary of Hierarchical Regression Analysis of Variables Predicting Threat (N=514)

	B	**SE**	**B**	**T**
Step1				
Highest Education Level	0.006	0.08	0.003	0.07
Sex	0.19	0.09	0.09	2.11
Age	0.04	0.04	0.04	0.89
Employment	0.006	0.06	0.01	0.11
Step 2				
Highest Education Level	0.09	0.07	0.05	1.35
Sex	0.16	0.07	0.08	2.32
Age	0.06	0.03	0.06	1.63
Employment	-0.03	0.04	-0.02	-0.59
Knowledge	0.16	0.09	0.06	1.66
Familiarity	-2.51	0.14	-0.62	-17.68
Step 3				
Highest Education Level	0.10	0.06	0.05	1.52
Sex	0.17	0.07	0.08	2.47**
Age	0.03	0.03	0.04	1.03
Employment	0.03	0.04	-0.03	-0.78
Knowledge	0.15	0.09	0.06	1.70
Familiarity	-1.73	-0.42	-0.42	-9.69**
Ethnicity	-0.47	0.09	0.24	-5.17**
VI	-0.007	0.01	0.01	0.31
HI	-0.08	-0.12	-0.12	-3.29**
VC	0.03	0.07	0.07	1.84
HC	0.06	0.08	0.08	2.90**

*Note. Statistical significance: *p < .05; **p < .01*

The hierarchical multiple regression revealed that at stage one, Demographic Factors did not significantly contribute to the regression model R^2 =0.01, F(4, 514)=1.31, p=0.27) (See Table 6.4.4.4). Introducing the Attitudinal Variables (Knowledge and Familiarity) the model was significantly improved; R^2=0.389, F(6,512)=54.36, p<0.001),

ΔR^2=0.38, F(2,512)=138.842, p<0.002 . Adding Ethnicity and Cultural variables further improved the model and the change in R^2 was also significant; R^2=0.448, F(11,507)=37.39, p<0.001), ΔR^2=0.44, F(3,507)=10.79, p<0.001. The most important predictor of Threat was Familiarity.

The same procedure was repeated for the *'Perceived Control'* variable. Similarly none of the assumptions were violated in this analysis. Three-stage hierarchical multiple regression was then conducted with Perceived Control being the dependent variable. Stage one consisted of the demographic variables (highest education level, age, sex and employment). The attitudinal variables (Familiarity and Knowledge) were entered at stage 2. And at the final stage ethnic and cultural variables (Ethnicity, Horizontal-Vertical Collectivism/Individualism) were entered to the model. Inter-correlations amongst the variables are shown in Table 6.4.4.3 and the regression statistics are being shown in Table 6.4.4.4.

Table 6.4.4.3

Correlations Among and Descriptive Statistics for the Perceived Control Dimension (N = 514)

	M	SD	1	2	3	4	5	6	7	8	9	10	11	12
Perceived Control(1)	0	1												
Sex(2)	1.61	0.49	-.01											
Age(3)	2.48	1.09	-.01	-.2										
Employment(4)	1.55	0.81	-.08	.08	-.30									
Education (5)	2.64	0.56	-.04	-04	.05	-.31								
Familiarity(6)	1.34	0.24	-.36	-.03	.04	-.08	.10							
Knowledge(7)	2.18	0.38	-.03	-.02	-.08	-.03	.02	-.33						
Ethnicity(8)	1.49	0.50	-.45	-.05	-.08	-.06	.09	.63	.04					
HI (9)	6.67	1.53	-.08	.05	.01	.02	.001	.30	-.08	.33				
VI (10)	5.44	1.78	-.14	.03	-.03	-.03	.02	.18	.02	.18	.24			
HC(11)	7.40	1.29	.17	.07	.08	-.08	.02	-.16	.03	-.26	.02	-.05		
VC (12)	6.53	2.23	.19	.04	.03	.01	-.01	-.28	-.22	-.30	.02	-.41	.30	

Note. Statistical significance: (p < .05; ± r=0.13, p < .01; p < .001, ± r=0.09

Table: 6.4.4.4

Summary of Hierarchical Regression Analysis for Variables Predicting Perceived Control (N=514)

	B	SE	B	T
Step1				
Highest Education Level	-0.02	0.08	-0.01	-0.26
Sex	-0.02	0.09	0.01	0.27
Age	0.01	0.04	0.12	0.27
Employment	0.09	0.06	0.08	1.70
Step 2				
Highest Education Level	0.03	0.08	0.02	0.38
Sex	-0.04	0.08	-0.02	-0.49
Age	0.02	0.04	0.018	0.38
Employment	0.07	0.05	0.06	1.38
Knowledge	-0.10	0.11	-0.04	-0.91
Familiarity	-1.51	0.17	-0.37	-8.92**
Step 3				
Highest Education Level	0.05	0.07	0.03	-0.65
Sex	-0.08	0.08	-0.04	-1.08
Age	-0.03	0.04	-0.04	-0.85
Employment	0.07	0.05	0.05	1.14
Knowledge	-0.07	0.11	-0.03	-0.64
Familiarity	-0.59	0.21	-0.14	-2.79**
Ethnicity	-0.76	0.11	-0.38	-7.14***
VI	-0.04	0.03	-0.08	-1.69
HI	-0.07	0.03	-0.11	-2.50**
VC	0.04	0.03	0.08	0.32
HC	0.04	0.03	0.06	1.33

*Note. Statistical significance: *p <.05; **p < .01*

The hierarchical multiple regression revealed that at stage one, Demographic Factors did not significantly contribute to the regression model R^2 =0.007, (F (4, 514) = 0.92, p=0.45). Variance explained was increased after the introduction of the Attitudinal Variables (Knowledge and Familiarity) and this change in R^2 was significant; R^2=0.141 (F

(2, 512) =14.04, p< .001, ΔR^2=0.13, F(2,512)=39.99, p<0.001. Adding Ethnicity and Cultural variables to the model further explained additional variation in Perceived Control where the change in R^2 was also significant; R^2=0.24, F (11, 507)=14.51, p<0.001), ΔR^2=0.98, F(5,507)=13.08, p<0.001. The most important predictor of Perceived Control was found to be Ethnicity.

A further three-stage hierarchical multiple regression was then conducted with *'Pity'* being the dependent variable. None of the assumptions were violated in this analysis. At the first stage the demographic variables (highest education level, age, sex and employment) were included to the model. The attitudinal variables (Familiarity and Knowledge) were entered at stage 2. And at the final stage ethnic and cultural variables (Ethnicity, Horizontal-Vertical Collectivism/Individualism) were entered to the model. Inter-correlations amongst the variables are shown in 6.4.4.5 and the regression statistics are being shown in 6.4.4.6.

Table 6.4.4.5

Correlations Among and Descriptive Statistics for the Pity Dimension (N= 514)

	M	SD	1	2	3	4	5	6	7	8	9	10	11	12
Pity (1)	0	1												
Sex(2)	1.61	0.49	.03											
Age(3)	2.48	1.09	-.05	-.02										
Employment(4)	1.55	0.81	.11	.08	-.34									
Education(5)	2.64	0.56	-.16	-.04	.05	-.32								
Familiarity(6)	1.34	0.24	-.23	-.03	.04	-.08	.10							
Knowledge (7)	2.18	0.38	.01	-.02	-.08	-.03	.02	-.33						
Ethnicity(8)	1.49	0.50	.23	-.05	-.08	.06	.09	.63	.004					
HI (9)	6.67	1.53	-.04	.05	.01	.02	.001	.30	-.08	.33				
VI (10)	5.44	1.78	-.05	.003	-.03	-.03	.02	.18	.02	.18	.24			
HC (11)	7.40	1.29	.04	.07	.08	-.08	.02	-.16	.03	-.26	.02	-.05		
VC (12)	6.53	2.23	.23	.04	.03	.01	-.01	-.28	-.23	-.30	.02	-.41	.30	

Note. Statistical significance: (p < .05; ± r=0.13, p < .01; p < .001, ± r=0.09

Table 6.4.4.6

Summary of Hierarchical Regression Analysis for Variables Predicting Pity (N=514)

		B	SE	B	T
Step1					
	Highest Education Level	-0.260	0.082	-0.145	-2.161**
	Sex	0.045	0.089	0.022	0.510
	Age	-0.029	0.042	-0.031	-0.682
	Employment	0.054	0.054	0.048	0.995
Step 2					
	Highest Education Level	-0.231	0.081	-0.129	-2.865**
	Sex	0.036	0.087	0.018	0.418
	Age	-0.024	0.042	-0.026	-0.588
	Employment	0.043	0.053	0.038	0.799
	Knowledge	0.011	0.115	0.004	0.099
	Familiarity	-0.859	0.175	-0.026	-0.588
Step 3					
	Highest Education Level	-0.231	0.079	-0.129	-2.919**
	Sex	0.022	0.086	0.011	.256
	Age	-0.038	0.041	-0.923	.357
	Employment	0.035	0.113	0.013	.672
	Knowledge	0.035	0.113	0.013	.310
	Familiarity	-0.387	0.225	-0.095	-1.717
	Ethnicity	0.255	0.115	0.128	2.219**
	VI	-0.043	0.027	-0.077	-1.607
	HI	-0.004	0.029	-0.006	-0.134
	VC	0.096	0.023	0.211	4.200**
	HC	0.050	0.035	0.065	1.432

*Note. Statistical significance: *p < .05; **p < .01; ***p < .001.*

The results of the hierarchical multiple regression revealed that at stage one, Demographic Factors did significantly contribute to the regression model R^2 =0.031, F (4, 514) = 4.119, p=0.003),ΔR^2=0.024, F(2,512)=11.784 p=0.001.(See table 6.4.4.8). Variance explained in Pity was increased after the introduction of the Attitudinal Variables (Knowledge and Familiarity) and change in R^2 was also significant; R^2=0.07 (F (6, 512) = 6.789; p < .001, ΔR^2=0.043, F(2,512)=11.784, p<0.001. Adding Ethnicity and Cultural

variables to the model further explained additional variation in Pity where the change in R^2 was significant as well; R^2=0.345, (F(11, 507)=6.240, p<0.001, , ΔR^2=0.090, F(5,507)=5.243, p<0.001. The most important predictor of Pity was found to be Vertical Collectivism.

Finally a three-stage hierarchical multiple regression was conducted with the last dependent variable; *Hospitalisation.* None of the assumptions were violated in this analysis as well. At the first stage the demographic variables (highest education level, age, sex and employment) were included to the model. The attitudinal variables (Familiarity and Knowledge) were entered at stage 2. And at the final stage ethnic and cultural variables (Ethnicity, Horizontal-Vertical Collectivism/Individualism) were entered to the model. Inter-correlations amongst the variables are shown in Table 6.4.4.7 and the regression statistics are being shown in Table 6.4.4.8.

Table 6.4.4.7

Correlations Among and Descriptive Statistics for the Hospitalisation Dimension (N = 514)

	M	SD	1	2	3	4	5	6	7	8	9	10	11	12
Hospitalisation(1)	0	1												
Sex(2)	1.61	0.49	.01											
Age(3)	2.48	1.08	-.03	-.24										
Employment4)	1.54	0.80	-.06	.08	-.30									
Education (5)	2.64	0.56	-.03	-.04	.05	-.32								
Familiarity(6)	1.34	0.24	-.11	-.03	.04	.08	.10							
Knowledge(7)	2.18	0.37	.02	-.02	-.08	-.03	.02	-.33						
Ethnicity(8)	1.49	0.50	.14	-.05	-.08	-.06	.09	.63	.01					
HI(9)	6.66	1.53	-.06	.05	.01	.02	.01	.30	-.08	.33				
VI(10)	5.44	1.77	-.10	.01	-.03	-.03	.02	.18	.02	.18	.24			
HC(11)	7.40	1.29	.09	.07	.03	-.08	.02	-.16	.03	-.26	.02	-.05		
VC(12)	6.53	2.23	.05	.04	.03	.01	-.01	-.28	-.23	-.30	.02	-.41	.30	

Note. Statistical significance: (p < .05; ± r=0.13, p < .01; p < .001, ± r=0.092)

Table 6.4.4.8

Summary of Hierarchical Regression Analysis for Variables Predicting Hospitalisation (N=514)

	B	SE	B	**T**
Step1				
Highest Education Level	-0.108	0.083	-0.061	-1.306
Sex	-0.026	0.090	-0.013	0.290
Age	-0.501	0.043	-0.055	-1.195
Employment	-0.114	0.055	-0.101	-2.083**
Step 2				
Highest Education Level	-0.091	0.083	-0.051	-0.101
Sex	0.020	0.089	0.010	0.223
Age	-0.052	0.043	-0.056	1.212
Employment	-0.123	0.055	-0.109	-2.249**
Knowledge	-0.092	0.118	-0.034	-0.778
Familiarity	-1.505	0.169	-0.368	-8.924**
Step 3				
Highest Education Level	-0.112	0.079	-0.062	-1.422
Sex	0.023	0.085	0.011	0.272
Age	-0.015	0.041	-0.016	-0.361
Employment	-0.098	0.052	-0.087	-1.883
Knowledge	-0.116	0.113	-0.043	-1.028
Familiarity	-01.414	0.224	-0.346	-6.315**
Ethnicity	-0.781	0.114	-0.391	-6.851**
VI	-0.072	0.027	-0.127	-2.677**
HI	-0.003	0.029	-0.005	-0.112
VC	0.042	0.023	0.092	1.847
HC	0.088	0.035	0.113	0.530**

*Note. Statistical significance: *p < .05; **p < .01; ***p < .001.*

The results of the hierarchical multiple regression revealed that at stage one demographic factors did not significantly contribute to the regression model R^2 =0.010 (F (4, 514) = 1.31, p=0.27. Variance explained was increased after the introduction of the Attitudinal Variables (Knowledge and Familiarity) and this change in R^2 was significant,

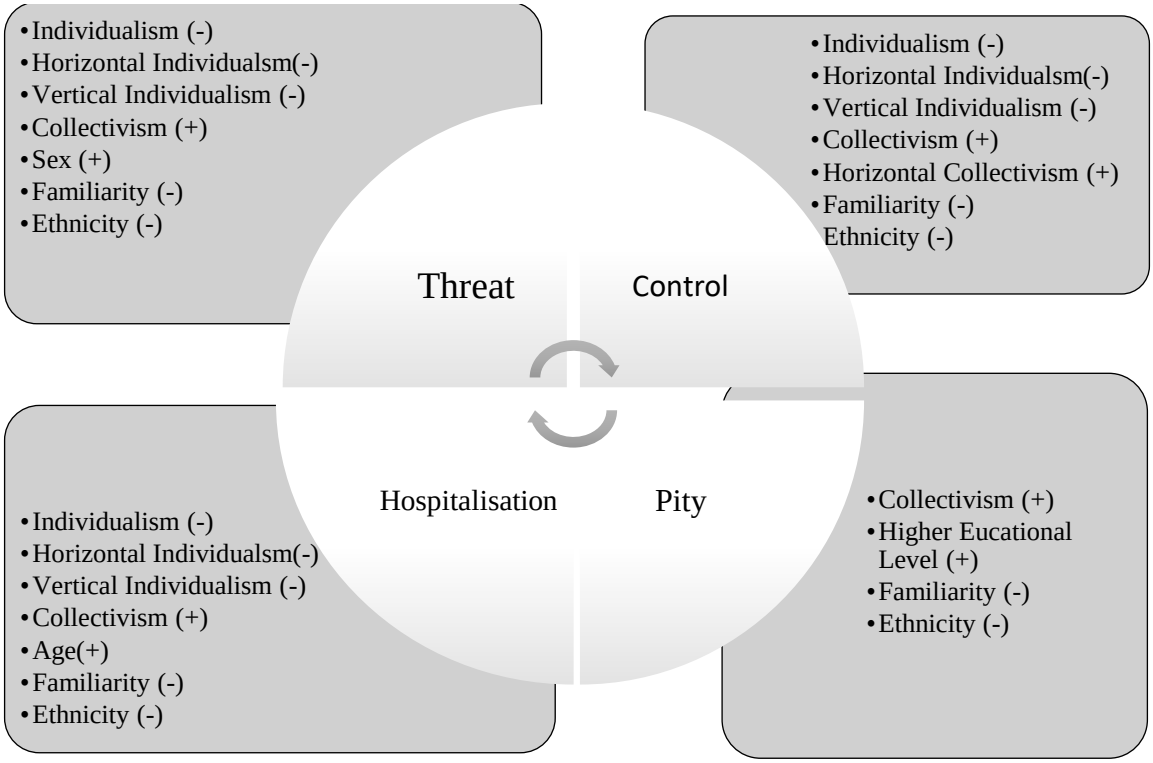
R^2=0.025 (F (6, 512) = 2.20, p = .041, ΔR^2=0.02, F(2,512)=3.96, p=0.02. Adding Ethnicity and Cultural variables to the model further explained additional variance in Hospitalization where the change in R^2 was also significant; R^2=0.13, F(11, 507)=6.98, p<0.001, ΔR^2=0.106, F(5,507)=12.41, p<0.001. The most important predictor of Hospitalization was found to be Ethnicity.

6.5 Discussion

As expected and in line with the pilot study's results, the findings of this study showed that demographic factors, culture and familiarity play an important role on predicting the all four dimensions of mental illness stigma; Threat, Control, Pity and Hospitalisation (See Figure 6.5.1). Unexpectedly, however, knowledge was not found to be a predictive factor of these dimensions (See Figure 6.5.1). Results of the findings are further discussed in this section.

Figure 6.5.1

Figural Display of the relationship between the 4 dimensions of MI stigma and factors contributing to it.



6.5.2 Threat Dimension of Stigma

Previous research done in the field suggested that one of the most common misconceptions about mental illness and those with mental health problems is dangerousness (Corrigan et al., 2011; Feldman & Crandall, 2007; Angermeyer & Matschinger, 1996). Due to this, general public commonly fear from and feel threatened by those with mental illness. According to Corrigan (2004) perceptions of threat can arouse as a result of the social cues that are attributed to individuals with mental illness. Such cues can be evident via psychiatric symptoms, unusual physical appearance or social interactions. When the members of the society are faced with these individuals, they may, therefore, feel discomfort and threatened.

As expected the findings of this study showed that TC participants perceived individuals with mental illness as more threatening compared to the GC Cypriot

participants. It was also found that those who lack familiarity with mental illness and are collective in their culture are more likely to report perceptions of threat (See Figure 6.5.1). Parallel to the findings of this research previous work done in the field also showed that such perceptions are more evident individuals who lack familiarity with mental illness (Sowislo, Gonet-Wirz, Lang & Huber, 2017; Corrigan et al., 2003; Holmes et al., 1999). For example a recent representative survey (N=2,207) carried out by Sowislo et al. (2017) in Switzerland showed how these two concepts might be related to each other. In their survey Sowislo et al. (2017) represented their participants with a perceived dangerousness scale that consisted of constructs as feelings of fear, threat and danger to self & public. Participants were asked to complete the scale after reading a vignette that either displayed an individual with psychiatric symptoms or a fictitious character who had been admitted to a mental health institution. Results of the Sowislo et al.'s (2017) study showed that familiarity significantly reduced the perception of dangerousness and the feelings of threat for both psychiatric treatment and psychiatric symptom conditions. When researchers investigated the sources of familiarity further, they found that participants who had lower levels of dangerousness perceptions also reported being familiar with mental illness personally or through a family member or a friend. When these groups were compared in relation to their dangerousness and threat perceptions no significant differences were found amongst them. This suggests that having familiarity through one to one contact is an effective way in decreasing perceptions of dangerousness and feelings of threat consequently stigma towards individuals who display symptoms of mental illness as well as towards those who had been hospitalised. As the results of this study showed when compared with the TC participants who reported familiarity through media, GC participants

reported familiarity through work or social circle; 88.2% of GC reported having a family or friend who has mental illness, this ratio was 34% for the TC participants. Further to this while majority of the GC participants (%57.4) reported working with someone who has mental illness, only a small portion of the TC participants (23.5%) reported having a colleague who has mental illness.

Looking at these results it could be argued that through having a family or friend who has mental illness or through working with a colleague with mental health problems had created a sustainable contact for the majority of the GC participants. As this contact comes through family or work it is likely to be positive. When there is a positive and sustainable contact individuals are less likely to experience negative feelings as fear of actual physical danger, vulnerability, uneasiness or guilt that may all lead to perceptions of threat. This is also in parallel with Stangor and Crandall's (2000) theory, which argues that perceived thereat; (fear, shame, social communication) leads to stigma formation.

Further to this it could be argued that GCs have more opportunity to interact with individuals with mental illness on a daily basis, consequently increasing their awareness about mental health and illness. More importantly it could be argued that through this awareness and contact they GC participants were better able to lessen the misconceptions about mental illness particularly around the threat perception, which was reflected in their AQ-27 scale scores.

Parallel with this as mentioned in Chapters 2 and 5 previous work done in the field of mental illness stigma suggests that socially constructed stereotypes mainly around threat and dangerousness of those with mental illness are being maintained in societies through

media (Corrigan, Powel & Michaels, 2013). In their study, Corrigan et al. (2013) aimed to assess the impact of reading a positive, neutral or a negative journal article about mental illness on attitudes using an experimental design. For the purpose of this research participants were randomly assigned to one of the three conditions and were asked to complete the Attribution Questionnaire and the Stigma through Knowledge test (STKT). The results of the experiment showed that the group who read a positive journal article about recovery, empowerment and self-determination reported the most affirming attitudes compared to the group who read the negative journal article about the dysfunctional nature of an individual with mental illness.

In the context of this thesis, the negative portrayal of individuals with mental illness in media had been well documented in Turkey (Çam & Çuhadar, 2011). Turkish newspapers and TV channels are read and watched daily by almost all of the Turkish speaking Cypriots. For this reason the negative impact of such portrayals can be expected to found within the Turkish speaking Cypriot community. This could be particularly the case considering the fact that 90% of the TC participants in this study reported being familiar with mental illness through Film/Television programs. In support to this Boke, Aker, Aler, Sarısoy and Şahin carried out a study (2007) by reviewing the 12 national newspapers between 2001 and 2006 to explore the meaning attributed to schizophrenia in Turkish written media. Their study's results showed that, the term 'Schizophrenia' or 'Schizophrenic' appeared very often in the written media; once every 2.2 days. The results also showed that 44.1% of the searched terms were used metaphorically that is defined as having antagonistic qualities that has nothing to do with the actual symptoms of schizophrenia. This creates a major problem for the public's understanding of schizophrenia. This is because, such portrayals of

schizophrenia in media suggest that, people with schizophrenia can shift from one extreme to another and, therefore, are unpredictable and threatening.

A study carried out in Greece by Economou et al. (2015) that explored the representations of mental illness in the Greek press between 2001 and 2011, on the other hand, showed the positive change in the representation of mental illness particularly schizophrenia in press. It was also found that stigmatising attitudes of the public had lessened as a result of more neutral nature of the press. In this study 50.8% of the GC participants reported being familiar with mental illness through film or a television program. Perhaps this support Economou et al.'s (2015) study as well as offering a more recent information by suggesting that the media representation of individuals with mental illness within the Greek speaking communities in general are becoming more positive and responsible. This is reflected on various studies' findings in regards to positive shift in Greek communities' attitudes since 1990s (Economou et al., 2012; Papadopoulos's et al., 2009; Zorba et al., 2015)

These studies suggest that the mass media can be used to fight stigma of mental illness across the communities. The use of mass media in most of the communities such as Turkey and Turkish speaking Cypriot communities, however, still remain negative. Generally individuals with mental illness are reflected as being dangerous criminals in these communities. There is no question that such reflections will lead to an increase in public's threat and dangerousness perceptions about individuals with mental illness especially if no other contact options are in place. This consequently will lead to higher levels of stigma towards mental illness. When compared to GC participants, the negative media portrayal combined with a lack of one to one contact with those who have mental illness can,

therefore, be thought as significant factors that increased the perceptions of threat and negative attitudes in the TC community.

Apart from familiarity culture was also an important predictor of the threat dimension of stigma. Results showed that participants who identify with the collective culture reported more perceptions of threat when being around individuals with mental illness. This was particularly the case for horizontal collectivism. As defined in Chapter 2 Triandis (2012) noted that while individualistic cultures value curiosity and creativity, collective societies value social relationships, in-group harmony and security. Negative stereotypes about individuals with mental illness as unpredictability and dangerousness is likely to increase lay individuals' feelings of threat. For the collective communities this feeling may be higher because mental illness or being around with someone who has a mental health problem may be possessing a threat to both physical safety 'tangible' as well as to the beliefs and values 'symbolic' of a group that dictates order, the group's togetherness and harmony (Esses & Beaufoy, 1994). Such domains carry a greater importance for the collective communities as they create reduce ambiguity and uncertainty, which are highly undesirable in collective communities (Hofstede, 2011).

Further to these, there were also several differences between the males and females participants in regards to the threat dimension of stigma. It was found that women perceived individuals with mental illness, as being more threatening than males, however, females and males did not differ in their endorsements of other dimensions of stigma; perceived control, pity and hospitalization (See Figure 6.5.1). Previous studies reported that women express more positive feelings towards those with mental health problems compared to men (Angermeyer & Matschinger, 2003; 2004; Angermeyer et al., 1998;

Corrigan et al., 2003; Kabir et al., 2004; Brown, 2008). Researchers as Angermeyer & Matschinger, (2003; 2004); Angermeyer et al., (1998), however, noted that women feel more anxious than men about individuals with mental illness. This supports the findings of this research, which suggest that although attitudes of men and women towards mental illness did not differ, women reported more feelings of threat towards those with mental illness.

Parallel with this in a study carried out in Nigeria by Kabir et al. (2004) it was also found that majority of the female participants (79.2%) reported feelings of threat compared to a fifth of males in the study. They explained this in terms of empathy. According to researchers as McLean and Anderson (2009) men and women differ in terms of risk taking behaviour and empathy levels, which may be impacting on their attitudes towards mental illness. While women were found to score high on the Empathy scale men were more likely to engage in risk-taking behaviour. This may due to the fact that from an early age males are expected to cope with more dangerous situation thus they develop better coping strategies in risky situations subsequently leading to lower levels of fear and anxiety. Women, on the other hand, are reported to have higher levels of danger perception in various situations. This suggests that while women maybe more likely to display empathetic attitudes towards those with mental health problems they are also more likely than males to report higher levels of fear and perceptions of threat. Since this study did not consider empathy levels and likelihood of risk taking behaviour it is not possible to suggest how these factors may have influenced the findings of this study. More studies are, therefore, needed that focus on empathy levels, and risk taking behaviour in relation to attitudes towards mental illness.

6.5.3 Control Dimension of Mental Illness stigma

As expected TCs attributed more control on individuals with mental illness compared to the GC participants. The results of the study also showed that ethnicity and culture were the predictor factors of perceived control. As mentioned in Chapter 2 the level of control attributed to an individual due to his/her illness will vary depending on the perceptions about the cause of mental illness, which is influenced by one's culture and ethnic orientation.

A partial support to this finding comes from studies that examined the attribution of success and failure to internal and external causes across different ethnic groups. For example in his study Imada (2012) assessed American and Japanese school textbooks for their cultural values. For the purpose of his study Imada reviewed 72 American and 71 Japanese textbooks and results showed that more individualist oriented themes such as self-direction and achievement were found in the American textbooks. Japanese textbooks, on the other hand, consisted of more collective themes such as conformity and group harmony. An interesting finding of this research was that in the Japanese textbooks failure was attributed to internal causes as character or personality, where as in the American books failure was attributed to external factors such as environmental situations. Similarly an earlier study carried out by Endo and Meijer (2004) also found that while North Americans who are believed to be individualist were more likely to attribute success to internal factors, East Asians who are believed to be collective were more likely to attribute success to external and failure to internal factors.

It could, therefore, be argued that in collective cultures more internal attributions are made to explain mental illness. This is because particularly in these cultures mental illness is generally viewed as a failure of the individual to obey the norms or it may be seen as a personality weakness (See Chapter 2). Because such internal qualities as weak or disobedient personality cannot be changed, more negative feelings as fear and blame may be felt towards that individual consequently resulting in higher levels of stigma.

Further to these those with lower levels of familiarity were also more likely to report higher perceptions of control. Previous research carried out in the field also suggest that sustainable interpersonal contact with a person who has mental illness helps debunk the myths about a condition being under the individual's control (Corrigan, 2000). For example in a recent cross-sectional questionnaire based study carried out by Nielsen and Townsend (2017) public's attitudes towards self-harm was explored using the attribution model of public discrimination. A total of 355 participants were represented with one of the ten vignettes describing a person who was self-harming and then were asked to complete a self-report measure to assess empathy, familiarity, perceived responsibility, dangerousness and helping/rejecting intentions. The controllability of the condition was manipulated by the researchers; controllable, uncontrollable and unknown.

Self-harm was further manipulated in this study; interpersonal, intrapersonal and unknown. Results showed that participants who were in the controllable cause condition attributed significantly more blame to individuals with mental illness for their health problems compared to those in the uncontrollable cause conditions. Further to these those who attributed more control to individuals with mental illness were also more likely to desire social distance from these individuals. Results, however, also showed that those who

were familiar with mental illness in the control condition were less likely to attribute control to the individual for his/ her mental illness. This is also in line with Corrigan et al.'s (2003) study which indicates that while one to one contact reduces blame, perceptions of control and dangerousness leads to an increase in the blame dimension of stigma.

Esterberg and Compton (2006) suggests that knowing someone who has received a mental health treatment might indicate a higher exposure to the mental health systems. Professionals who work in such institutions generally conceptualise mental illness using factual knowledge rather than myths. Previous research done in the field had shown that the use of professionals who can correctly inform the public about mental illness is an effective way to increase awareness to these health conditions consequently reducing stigma (Stuart, 2016). It may also be argued that some etiological theories may be ruled out by the members of the general public as a result of knowing someone with mental illness (Martinez, 2010). This is to suggest that knowing someone with mental illness, the individual's personal history, upbringing and personality may prevent the attribution of the cause of illness to bad character or upbringing, which reduces mental illness stigma (Corrigan, 2000).

Looking at these studies it could, therefore, be suggested that compared to GC community, TC community members are more likely to attribute control to the internal factors as genetic or personality which in turn increases their perceptions of control and attributions of blame to individuals with mental illness consequently stigma.

6.5.4 Pity Dimension of Mental Illness Stigma

Pity was also one of the dimensions of stigma extracted in this study. Unexpectedly, however, findings showed that familiarity was negatively related to the pity dimension of mental illness stigma. Previous research done in the filed commonly noted that those who are more familiar with mental illness generally have higher levels of pity (Rössler, 2016; Corrigan et al., 2003). Commonly these studies report pity as a positive feeling that leads to helping behaviour.

There are, however, several studies, which suggest that although pity can have a positive impact on attitudes towards mental illness it may also result in negative reactions such as blame, anger and discrimination. For example a study carried out by Fominaya, Corrigan and Rusch (2016) aimed at assessing the effects of pity on self and public's perceptions of individuals with mental illness showed how pity may lead to negative reactions towards individuals with mental illness. For the purpose of their study they recruited 75 participants with serious mental illness who were asked to complete measures of pity, public and self-stigma as well as depression and quality of life. Results showed a strong significant relationship between self and public stigma, pity and decreased quality of life at a baseline. On follow up after six months, there were still correlations between the anger, fear, avoidance and pity dimensions of stigma.

Perhaps these results can be further explained by looking at the definition of Pity. By definition pity refers to '*A feeling of sympathy at the misfortune or suffering of someone or something.'* (Marshall & Bleakley, 2014, p.9). It could, therefore, be argued that the pity perceptions arose as a result of viewing a person with mental illness as misfortunate due to his/her condition. Views as these can in fact result in discrimination because they signal a difference, which can lead to a separation of individuals with mental illness from their

societies. As discussed in Chapter 2 this is also consistent with the Labeling Theory, which suggests that when individuals are perceived differently due to having a certain characteristic, they may become marginalized in their communities, which leads to them being labeled, separated and discriminated (Link et al., 1989). In a consistent manner a study carried out by Horch and Hodgins (2008) also showed that those who devalue and discriminate people with mental illness tend to score higher on the anger and pity dimensions of stigma.

It may be that those who are more familiar with mental illness are less likely to perceive individuals as being misfortunate, therefore, less likely to label them as different consequently leading to a lower levels of pity and stigma. Particularly in the case of GC participants who reported higher exposure to mental illness via work might have reduced feelings of pity as this prevents public to label persons with mental illness as being different or misfortunate.

An increased attention is now being given to feelings of compassion rather than pity as it had been found to that feelings of compassion lead to lower levels of stigma (Brener, et al., 2018; Wong, Mak & Liao, 2016, Gold, 2015). According to these researchers although both compassion and pity are examples of reactions to someone's misfortune, compassion involves more commitment for substantial help where as pity does not necessarily increase personal involvement. Perhaps the most important distinction between pity and compassion is that while compassion emphasizes equality, pity emphasizes inferiority. This suggests an individual who pities someone with mental illness, is seen as a superior and the person who is pitied is seen as an inferior (Catwright, 1984), which may lead to discrimination and stigmatization.

According to Hutter and Friedland (2013) although members of the public may feel pity for those who have mental illness, they are likely to desire personal distance or feel as if they are unable to help due to their own personal commitments. Further to these, it had been suggested by the previous researchers that feelings of pity might arose from stereotypical beliefs (Dovidio, Hewstone, Glick & Esses, 2010). Specific to mental illness such stereotypical beliefs may be a) a person with mental illness is responsible for his/her condition, b) inferior condition can not be changed and c) beliefs about inability to help (Ahmedani, 2011). It had been found by this and supported by the previous research that those who are familiar with mental illness are less likely to hold individual responsible for their illness. It may be argued that because individuals with higher levels of familiarity are more likely to know how to help those with mental illness, they are less likely to see mental illness as a misfortune and more likely to explain it empirically and thus report lower levels of pity towards those with mental illness. Parallel to this a study carried out by Hing, Russel and Gainsbury (2016) aimed at assessing negative attitudes towards people who are experiencing a gambling problem. Two thousand participants were recruited from Victoria, Australia and were represented with a vignette about an individual with gambling behaviour. Participants were then asked to complete demographic, familiarity with gambling and stigma related measures. Results showed that individuals who were familiar with a person who is experiencing a gambling problem held less stereotypical beliefs such as they were less likely to state that the person's problem was due to his bad character. It was also found that participants who held stereotypical beliefs also reported feelings of pity towards the individuals. According to the researchers viewing individuals with such

problems as pitiable can result in these individuals being seen as incapable and in need of constant assistance.

Findings of the Hing et al. (2016) study also showed that individuals with mental health conditions in fact do not want to be pitied but instead they wish to be treated the same as everyone else. This suggests that although previously introduced as a stigma dimension that positively influences attitudes (Corrigan, 2000), feelings of pity can also result in stigmatization of individuals with mental illness. Increasing one to one contact can reduce such feelings while increasing compassion, which is seen to be a more promising feeling that increases one's commitment to be personally involved and engage in helping behaviour (Frazer, 2006), consequently leading to a lower levels of discrimination and stigma. As compassion was not assessed in this study it is not possible to state that familiarity is linked with feelings of compassion but this suggests that future attention should be given to exploring compassion and its link with mental illness stigma.

The results of the study also showed that pity was inversely related to Individualism but had a positive relationship with collectivism particularly with VC. The one reason to why this might be is that those who have more collectivist orientations were also found to have lower levels of familiarity compared to those with a more individualist orientation in this research. It may also be explained in terms of the differences between individualist and collectivist societies in regards to their social behaviour. Previous research showed that those with a more individualist orientation have more 'ego-focused' emotions as anger, pride and frustration. Individuals with a more collective orientation, however, were observed to have more 'other-focused' emotions such as sympathy, pity and shame (Kitayama &Markus, 1994). As a feeling, pity consists of an "other focused" orientation,

which requires an individual to realize others' misfortune. This is in line with the characteristics of a collective orientation as being concerned for others (Hui & Triandis, 1986). This may, therefore, not be compatible with a more 'ego-focused' individualist orientation (Kitayama & Markus, 1994). For this reason it might be argued that participants of this research who displayed more collective orientation were also more likely to feel pity towards those who have mental illness which seem to be increasing the levels of mental illness stigma.

Further to these, education levels were also found to have an impact on the Pity dimension of stigma; those who were educated to a higher level also reported higher levels of Pity towards those with mental health problems (See Figure 6.5.1). Parallel with this previous studies reported that higher education levels are related to emotions as empathy and pity. For example, Peluso and Blay's (2009) study showed that participants with higher education reported more pity towards those with mental health problems. Previous research suggests that individuals with higher education tend to report less feeling as fear (Angermeyer & Matschinger, 2004; Brockington et al., 1993) and anger (Angermeyer & Matschinger, 2004) than those with low educational achievements. It may, therefore, be argued that although those who have high education attainment may be less likely to hold stereotypical beliefs about mental illness as dangerousness and thus report lower levels of fear, they may be more likely to see individuals with mental illness as being less fortunate or being different which leads to higher levels of pity. There are, however, couple of studies that contradicts with the findings of this thesis as Corrigan et al.'s (2003) and Penn & Nowlin-Drummond (2001) who noted no relationship between education and pity.

It should, also be noted that the education levels across the island of Cyprus is high; more than 87% of the population having at least an undergraduate degree (Kedir, Kyrizi & Martinez-Mora, 2012). It is, therefore, possible that people with lower levels of education are underrepresented and so the generalization of this finding may not be possible. There is a need for further studies to be carried out with more participants who have lower education levels in the field in order to be able to produce more generalizable results.

6.5.5 Hospitalisation Dimension of Mental Illness Stigma

Hospitalization was the last dimension of mental illness stigma to be extracted. In parallel with this, previous researchers as Link, Castille and Stuber (2008) noted that institutionalized practices that are designed for the care and treatment of those with mental illness carry a great importance as they can reduce, minimize or completely eliminate stigma within the communities. As defined by Link and Phelan (2001) stigma arises when elements of labeling, stereotyping and discrimination is evident. This definition may further help researchers to understand the link between hospitalization and stigma of mental illness. Hospitalisation involves placing individuals who are labeled due to having a mental illness into a separate environment and treating them differently, thus increasing stigma. This is supported by the 'Secondary Deviance' theory introduced by Lemert (1967), which refers to the extent to which individual's behaviour is seen as deviant or problematic within his/her community. Thus it separates those who are considered to be mainstream and those who are not. Practices are then employed to control these individuals who are not by placing them in institutions separate from those who are considered to be 'normal'. This inevitably disadvantages individuals with mental illness, as they are withdrawn from their communities, they loose ability to function effectively, are less able to be employed and get

housing, and in general to socialize with others. The more this separation and isolation occurs the higher levels of stigma will also arise (Link, Castille & Stubber, 2008).

The results of the study also showed that ethnicity, cultural orientation, familiarity and age were the predictors of the hospitalization dimension. As expected TCs who were more collective and had lower levels of familiarity endorsed statements about hospitalization of those with mental illness more compared to a more individualist GCs who reported higher levels of familiarity. Previous work done in the field suggests that if one perceives individual as responsible and in control of his/her behaviour and illness, they are more likely to perceive such individual as dangerous, therefore, threatening (Carey & Sarma, 2016). These perceptions in turn result in higher desire to be socially distant from the individual (Corrigan et al., 2003). As reported earlier in this chapter compared to GC participants, TC participants scored higher both on the 'Control' and 'Threat' dimensions of stigma. According to Corrigan et al. (2003) this could have impacted on the higher levels of 'Hospitalisation' dimensions found in this group.

In their earlier study Corrigan, Watson, Warpinski and Garcia (2004) also showed the link between pity and hospitalization dimensions of stigma. Their study aimed at testing the psychosocial model introduced by Skitka and Tetlock (1992), which suggests that decisions made by the policy makers in regards to the allocation of resources to mental health services are influenced by their attitudes towards mental illness. In order to test the theory Corrigan et al. (2004) recruited 54 participants who were asked to complete variousmeasures of resource allocation preferences for mandated treatment and rehabilitation services, attributions about people with mental illness, and factors that influence allocation preferences such as perceived treatment efficacy. As they hypothesised

results showed a correlation between attitudes and allocation of resources for mandated treatment. An interesting finding was that participants who pitied those with mental illness were more likely to endorse coercive and segregated treatments of mental illness and so were also more in favour of more resources to be allocated to the mandated care. It may, therefore, be argued that TC participants in this study who reported more feelings of pity towards individuals with mental illness were also more likely to perceive them as threatening and unable to live independently. As a result they were more likely than GC participants to support segregated treatment of mental illness.

Further to these according to Corrigan, et al. (2001), desire to be socially distant from those with mental illness are influenced by two types of prejudice. The first one is authoritarianism referring to a belief, which suggests that individuals with mental illness cannot care for themselves and should, therefore, be cared for by the health system. The second one is benevolence referring to a perception about an individual with mental illness being innocent and childlike. In their study, which was carried out with 151 participants, Corrigan et al. (2001) found that participants who reported having previous contact with someone with mental illness scored lower on both forms of prejudice. This was also supported recently by various researchers as Jang et al. (2012) who carried out a study to identify the factors that contribute to attitudes towards mental illness in Korea. A nationwide survey study consisted of 4,057 participants who were asked to complete an attitude, social distance, knowledge, familiarity questionnaires and a demographic information form. Similar to Corrigan et al.'s (2001) study findings Jang et al.'s (2012) study also found a negative relationship between familiarity and desire to be socially distant from those who have mental illness. They argued that this is because individuals with

previous contact with someone who has mental illness are less likely to hold prejudice towards the group, which in turn reduces avoidance and desire for social distance. This helps explain the less support given to hospitalization of individuals with mental illness by the GC participants.

Further to these results of this study also showed that older generation endorsed hospitalization of individuals with mental illness more. Historically, the label of 'mentally ill' used to be prominent within the societies. This label referred to a person that is seen as a deviant individual who lives in institutions (Fairweather, Sanders, Maynard & Cressler, 1969). This label also led to an elimination and discrimination of an individual from regular socialization. Such beliefs that caused stigma of mental illness were common particularly in 1960s up until 1980s (Fairweather, Sanders, Maynard & Cressler, 1969). This was also evident in the Mental Health Act of 1931 that was used in the Republic of Cyprus until 1997 and is still currently being used in the Northern part of the island that is occupied. The law states that individuals with mental illness can be arrested by the police officers to be put into a 'safe' place if he or she displays behaviour associated with mental illness. It also allows compulsory admission of individuals with mental illness to the hospitals. The older generation of this study were in their early adulthood in the 1960s and it may, therefore, be argued that they were exposed to such stigmatising attitudes more and due to this their attitudes were found to be more discriminatory particularly around the hospitalisation dimension of stigma. It could also be argued that the younger generation is more exposed to different life experiences through education and work compared to the older generation. This may have increased the likelihood of the younger generation to come into contact with someone who has mental illness (Yuan et al., 2016), thus making their attitudes more

positive around coercive and segregated treatments of mental health problems. Further to these Yuan et al.'s (2016) carried out a study to assess the underlying socio-demographic factors associated with mental illness within the general population of Singapore. They recruited 3,006 participants who were asked to fill in a demographic questionnaire as well as familiarity, knowledge and AMI questionnaires. As a result they reported a positive relation of the four dimensions of AMI questionnaire; social distancing, social restrictiveness, prejudice and misconception, and age. Their results are also consistent with previous work done in the field, which suggests that the older generation is less tolerant about mental illness (Subramaniam, 2016; Chong et al., 2007; Angermeyer & Dietrich, 2006). They argued that this might be because of the knowledge being easily accessible by the new generation who is familiar with the use of technology in this era. It should, however, be noted that the one must be careful about obtaining information through media as it may not reflect the truth about mental illness and individuals with mental health problems. Further studies are, therefore, needed in this area to assess the difference between older and younger generation in their attitudes and factors that may be related to it. It could also be argued that the older generation emphasised hospitalisation of individuals with mental illness more as they may not be familiar with the alternative treatments. As mentioned earlier the community-integrated treatment of mental illness is a relatively new concept in the Republic of Cyprus. It dates back to 1997 in Republic of Cyprus and it does not exist in the occupied part of the island. Due to this older generation might be less aware of the more recent treatments that are community integrated.

Moreover results of this study also showed the link between culture and the hospitalization dimension of mental illness stigma. It was found that those from a collective

orientation were more likely to endorse hospitalization of individuals with mental illness compared to those who were from individualist cultures. As mention in the previous chapters studies done in the filed showed that qualities as interdependence is emphasized within the collective cultures, such as Turkish and Asian (Breland et al., 2011) (See Chapters 2 & 5). People from these cultures tend to use higher levels of control, prioritize obedience and are more restraining during social interactions compared to those who emphasize independence (Chao, 1994; Dornbusch, Ritter, Leiderman, Roberts, & Fraleigh, 1987; Harwood, Miller, & Irrizary, 1995; Kagitcibasi 1970; Sinha, 1981). Symptoms associated with mental illness such as lack of self-control may be interpreted as being disobedient to cultural norms and values within the collective cultural groups. This in turn may signal the necessity of control over these individuals' lives consequently leading to more support given to the hospitalisation of them.

These results can also be explained looking at the social structures of the individualist and collectivist communities. According to Greif (1994) individualism and collectivism can be defined using the concepts of integration and segregation. To him the social structure in collective cultures is segregated as individuals interact with specific ethnic, religious or familial group. The social structure in individualist societies, on the other hand, is integrated as the interaction takes place amongst people from different groups. It could, therefore, be suggested that while in individualistic cultures those with mental illness may be seen as those to be integrated into the community, in collective cultures these individuals may be viewed as those to be disassociated and segregated from the community.

Lower levels of familiarity of the collective TC participants may also have played a role on this finding. In Angermeyet et al.'s (2004) study it was found that individuals who had familiarity with mental illness were less likely to fear from those with mental illness, less likely to hold dangerousness perceptions and less likely to desire avoiding from them. A more recent study carried out by Stuber, Rocha, Christian and Link (2014) aimed at comparing the attitudes of the U.S. general public and of mental health professionals towards people with mental illness as well as examining the factors that are negatively related to social distance. For the purpose of their study they recruited 731 participants. They were represented with two vignettes: depression and schizophrenia and then were asked to fill in attitude, familiarity, knowledge and social distance scales. Results of the regression analysis showed that familiarity was the negative predictor of social distance. These findings suggest that those who are more familiar with mental illness are less likely to support coercive treatment of individuals with mental health problems partly due to the fact that familiarity helps reduce stereotypical beliefs particularly around dangerousness (Hinton, 2017). Considering these studies' findings and the findings of this thesis it could be argued that as well as one's cultural orientation, familiarity levels also play a key role in predicting the hospitalisation dimension of mental illness and perhaps by increasing familiarity one can help reduce prejudicial beliefs about mental illness consequently improving attitudes towards those who have mental health problems.

6.5.6 General Evaluation of the Study Findings

Although greater levels of mental illness stigma was found within the Turkish speaking Cypriot participant group, it should be noted that stigma exist in the both of the Turkish and

Greek speaking Cypriot communities of Cyprus. Compared with previous research done in the countries where culture structure is similar to TC and GC communities, participants in this study report higher levels of stigma. For example, compared to a study done by de Sousa; Marques, Curral; Queirós (2012) in Portugal where high mean scores were obtained for Pity (M=6.89) and Coercion (M=6.87) dimensions of stigma, TC and GC participants of this study reported even higher mean scores for these dimensions; Pity (M=7.17) and Coercion (M=8.08). Further to these, while Portuguese participants reported a mean score of 3.11 dangerousness and 2.68 for the fear dimensions, Cypriot participants reported a mean score of 4.73 for dangerousness and 4.61 for the fear dimensions. This shows the existence of higher levels of negative attitudes and stereotypical beliefs found in the island compared to other similar societies. It is, therefore, needed for both of the Cypriot communities to take an immediate action to address stigma of mental illness collectively in their communities.

These findings are in line with previous research done particularly with the GC participants where the prevalence of high levels of mental health related stigma had been noted (Madianos et al., 1999; Economou, Richardson, Gramandani, Stalikas, & Stefanis 2005, Papadopoulos, 2009). It should, however, be noted that compared to TC participants GC ones are more positive towards mental illness and more efforts are being spent to further improve these attitudes through policies and regulations. The results of the current study, therefore, show a continuing positive shift in regards to attitudes towards mental health problems in GC community. As well as being more individualistic, GCs have also been found to perceive mental illness more positively and reported more favourable attitudes towards individuals with mental health problems. This could be explained in terms

of increasing efforts being spent within the GC community to reduce discrimination such as establishment of anti-discriminatory law, anti-stigma campaigns and transmission to community-integrated treatment.

As well as the more collective cultural structure, the less favourable attitudes found within the TC community may be attributed to the lack available services, policies, activities and campaigns on mental health in TC community. Researchers as Ahmedani (2011) and Knap and Byford (2006) reported that in particular lack of governmental input and funding on mental health and well-being that lead to lower levels of awareness and familiarity on mental health can partly explain negative attitudes and stigma towards mental illness in societies. It has been also noted that available services for the treatment of mental illness play a key role on informing public on mental health (Wedding, Boyd, & Niemiec, 2010; Harvey and Robinson, 2003).

This study makes a contribution to the existing understanding of attitudes towards mental illness. It brings a more holistic understanding of the causes of mental illness stigma by bringing culture into consideration, which has previously been underestimated, in stigma research. To researcher's knowledge this is a first comprehensive study to be carried out in Cyprus that consisted the two major ethnic groups that have a very troubled history. Now more efforts are being spend to bring peace back to the island for the Turkish and Greek Cypriots. Such bi-communal studies, therefore, carry even more importance in this era where efforts are being made to enable more collective atmosphere between the two communities. This study, therefore, allows policy makers, professionals and communities in general to be able to understand attitudes towards mental illness in either of the communities, better allowing them to work more collectively and effectively to diminish it

in both societies. It also informs the policy makers and mental health professionals on the current cultural structure of the Turkish and Greek speaking Cypriot communities and the impact of it on attitudes towards mental health so that they can be more sensitive, knowledgeable and efficient when preparing policies around mental health.

6.6 Limitations of the Study and Future Suggestions

Although this study contributes to our recent understanding of attitudes towards mental health problems consequently stigma and is a first comprehensive study to be carried out with a large sample of Turkish and Greek Cypriots it has some limitations that need to be considered. Probably the most important limitation of this study is the use of a non-randomised method. This limits researcher's ability to generalise the findings to wider Turkish and Greek Cypriot communities living abroad. Further to these a convenience sampling method was used in this study in order to be able to recruit large numbers of participants from both communities. Such sampling method has been associated with being low in generalizability as it creates a bias on the representativeness of the sample (Van Meter, 1990; Kaplan et al**.,** 1987). The tools that have been used to assess knowledge and culture could also be criticised. Evans-Lacko et al. (2012) noted the lack of valid measures in assessing knowledge in relation to mental health and well-being. There is, therefore, a need for more valid measurement tools within the field that allow researchers to better assess knowledge as a related construct of stigma. Triandis also noted the lack of satisfactory tools in assessing individualism/collectivism dimensions of culture.

Only few studies have tested the reliability of Triandis's Vertical/Horizontal/Indiviualism/Collectivism measurement tool. More studies that use this tool is needed in order to better establish the validity and reliability of it.

Another possible limitation in this study could be the way researcher used the term "mental illness". Considering the lack of knowledge on mental health and wellbeing this could have made Turkish and Greek speaking Cypriot participants to focus on specific mental health problem as schizophrenia while filling in the questionnaire. This could be partly explaining the negative attitudes reported by both groups of the participants but particularly those who are TC. Further to this future studies should assess empathy levels of the participants as well as gender perceptions in order to be able to better explain the differences highlighted between males and females on the threat dimension of stigma. Moreover, further investigation of pity dimension and its relationship with education levels are needed as previous research reports conflicting results in this area. It will also be ideal to assess compassion rather than pity when carrying out studies in the field of mental illness stigma. As mentioned earlier in this chapter compassion involves more willingness to be personally involved and help those with mental illness as well as emphasizing equality (Brener, et al., 2018). For this reason it may be a better prediction of discrimination that is the behavioural component of stigma (See Chapter 1).

6.7 Brief Conclusion

In conclusion this study showed that ethnicity and culture as well as familiarity levels carry a particular importance in predicting dimensions of stigma. Variations amongst the TC and GC participants in those factors had led to different levels of stigma being

expressed towards those with mental illness. The implications of this study, therefore, carry great importance for policy makers, professionals and the general public in their understanding of mental health related stigma and factors behind it. With this understanding collective efforts could hopefully be spent to reduce stigma levels towards individuals with mental illness across the island.

Chapter 7-Qualitative Study

7.1 Introduction

The quantitative phase of this study had given an initial understanding to what stigma of mental illness is and how it manifests in the Turkish and Greek speaking Cypriot communities of Cyprus. As mentioned in Chapter 2, stigma is a socially constructed complex nature that the researcher believes should be explored in depth. According to researchers as Daher, Carrè, Jaramillo, Olivares and Timicic, (2017) the use of a qualitative methodology is deemed more useful when trying to understand complex notions as stigma and culture (See Chapter 4). This chapter, therefore, deals with the processes of conducting semi-structured interviews, analysis of the gathered data using the Interpretive Phenomenological Analysis (IPA). The findings of the qualitative study and discussion sections are also included in this chapter, which will start with the interpretation of the superordinate and subordinate themes that have emerged throughout the conversations with the selected participants. The chapter will be concluded with a brief coverage of the general findings

7.2 Method of Analysis

IPA is known as one of the most popular methodological techniques to be used by the qualitative researchers. As mentioned in the methodological chapter of this thesis (Chapter 4) it is mainly used in order to examine the meaning, which each individual brings to their life experiences (Pietkiewicz & Smith, 2014). This technique is, therefore, commonly used when one's perspective about a certain phenomenon is ought to be understood. Considering the aforementioned aim of this chapter and the general aim of this thesis that is to assess the attitudes towards mental illness in Greek and Turkish speaking Cypriot communities and seek an explanation on the factors that contribute to these attitudes, it is vital for the researcher to understand and appreciate the unique experiences of the public with mental health and mental illness. It is also necessary to understand how one's personal experiences along with other factors as culture may have shaped and influenced one's attitudes towards mentally ill. For this reason IPA technique was deemed as the most suitable one to be used when collecting and analysing the interview data.

IPA as an approach to data analysis has 3 focuses; phenomenology, hermeneutics and idiography (See Chapter 4). It is this school's belief that interpretations are the only information we have about individual's experiences and perceptions, therefore, reality. In order to bring out the best possible interpretation one must use a hermeneutic cycle that is to read, reflect and interpret (Kim, 2013). In doing so the aim of the researcher will be to provide an evidence on how participants make sense of mental health and mental illness and how these perceptions and experiences shape their attitudes towards people with these conditions. As well as understanding the experiences of the participants, the researcher also seeks to document their sense making. She, therefore, will be moving back and forth

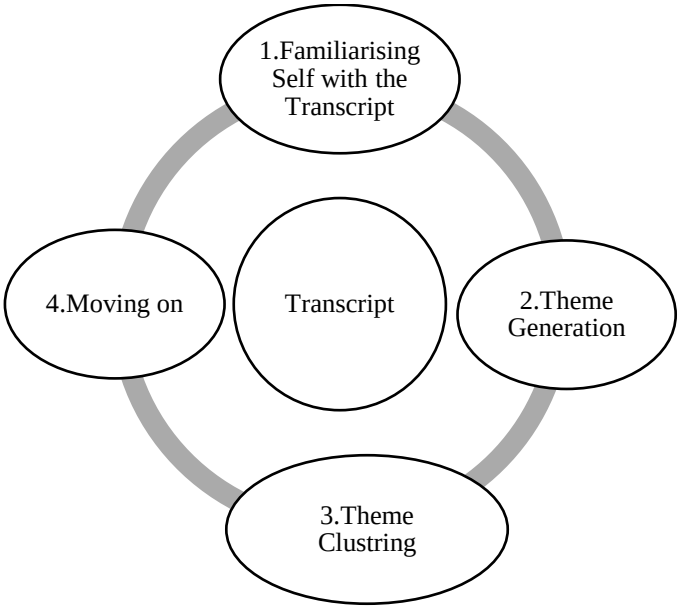
between the emic and etic perspectives, former referring to the perspectives of the individuals and the latter referring to the perspective of the researcher (Pietkiewicz & Smith, 2014). Paying attention to the etic perspective has been noted beneficial particularly in qualitative research due to its protective value against psychological reductionism that refers to the oversimplification of human mind and behaviour by generalising the way persons think and behave. Emic perspective on the other hand, helps researchers to objectively understand the phenomenon that they are investigating by obtaining the unique viewpoints from each of their participants. This leads to a better insight and also gives researchers a chance to develop more concise theories (Pietkiewicz, & Smith, 2014).

7.3 Steps of Data Analysis

It should be noted that there is not a set of guidelines in regards to the steps of data analysing that need to be followed by those adopting the IPA approach. In general, it is more flexible in this sense compared to other approaches as it provides suppler guidelines of data analysis that could be used by the researchers in order to answer their own research questions. In this thesis researcher adopted a four-staged approach to data analysis as noted in Shinebourne (2011) and Pietkiewicz and Smiths's (2014) articles on IPA data analysis.

This section of the chapter will, therefore, provide a step-by-step description of the data analysis adopted by the researchers when using the IPA approach (see Figure 7.3.1).

Figure 7.3.1 *Four-Step Analytical Approach to IPA Data Analysis*



7.3.2 Step 1-Becoming Familiar with the Transcript

An initial step is taken by the researcher in order to become familiar with each of the transcripts. This is generally achieved through reading and re-reading of the transcripts provided by the participants (See Appendix 9 & 10). Reading or listening to the transcripts several times may also bring out new insights on the phenomenon that is being researched. At this stage it is necessary for the researchers to take notes known as the exploratory notes of their observations. These notes can consists of what is being discussed by the participants (content), participants' use of language as pauses and repetitions and researcher's own initial interpretative notes (Shinebourne, 2011). It is important for the researchers to also highlight unique phrases as these will help in theme generation at later stages.

7.3.3 Step 2-Transforming notes into Emergent Themes

At this stage researchers move away from reading the transcripts and focus more on the notes that they took (Pietkiewicz & Smith, 2014; Shinebourne, 2011). The aim is to transform these notes into emerging themes. Themes could be the concise phrases that reflect a high level of abstraction which enable contextual understanding of the notes. The focus remains on the particular participant's account, however, researcher is under the influence from the readings of the whole transcript, which is an example of the aforementioned emic and etic perspectives (See Appendix 10).

7.3.4 Step 3-Relating and Clustering Emergent Themes

Once the emergent themes are identified researchers can move to the third stage that involves them looking for the links between these themes. Researchers' aim is to be able to group the themes in accordance with their similarity in content and concepts. This is followed with labeling each cluster with a descriptive label, which is known as a superordinate theme. At this stage researchers may also decide to exclude some of the emergent themes from the analysis if they do not fit in with the general structure. It is expected to provide a list of the superordinate and subordinate themes along with the short extracts from the interview transcript (Pietkiewicz & Smiths, 2014).

7.3.5 Step 4- Final Stage; Production of a Table of Themes

At the final stage, researchers produce a table that consists of the superordinate and subordinate themes. As noted by Eatough and Smith (2017), '*for a researcher, this table is the outcome of an iterative process in which she/he has moved back and forth between the various analytic stages ensuring that the integrity of what the participant said has been preserved as far as possible. If the researcher has been successful, then it should be*

possible for someone else to track the analytic journey from the raw data through to the end table' (p. 120).

After all participants' transcripts are analysed and tables for the themes are created for each of the transcripts, researcher gathers them together in a final table of the themes that correspond to the whole study. This iterative process requires researchers to repeatedly check participants' transcripts, compare the themes with each other and make any necessary changes. At this stage it is important to consider the re-occurrence of the data but also the richness of it in explaining the themes at a sufficient level (Shinebourne, 2011).

7.4 Method

In total, 21 interviewees were recruited for this study. Eight of these individuals defined their ethnicity as GC while 13 of them defined their ethnicity as TC. Participants were recruited from the list of individuals who previously took part in the quantitative study and had given their consent to be a potential participant in the qualitative phase of the research. All of the participants were born and raised in Cyprus and their age ranged from 20 to 65 (please see Table 7.4.2). Interviews with the participants lasted a minimum of 30 minutes and a maximum of an hour. All the interviews were carried out in a private location convenient for the participants; homes or work places. Interviews were carried out on a one-to one basis and they were audio-recorded for analyses purposes. Participants

were given pseudonyms to ensure privacy. The protocol of the semi-structured interviews is given in Table 7.4.1.

Table 7.4.1

The semi-structure interview protocol used with TC and GC Participants

Questions	Probes
Can you tell me about your culture?	Values, norms, traditions, in-group-out-group relationship,
How do Greek and Turkish Cypriot cultural values may influence perceptions of mentally ill and why?	Collectivism, individualism, societal structure, independence and interdependence
Why people with mental health problems are viewed as threatening?	Attribution: Internal/External Dependence/Interdependence, Ego/other focused
What can and should be done in order to reduce mental illness stigma within the two communities?	Professionals, Policies and Regulations, Media, Education System)

The researcher created these interview questions in order to shed a light to the findings of the quantitative study noted in the previous chapters (See Chapters 5 &6). As most of the participants had a sufficient level of English most of the interviews were carried out in English language. It should, however, be noted that five interviews with the TC participants were carried out in their native language due to them not being comfortable in answering questions in English. The transcripts obtained from these interviewees were analysed in Turkish, as the researcher is native in the language. Same questions were asked to all of the participants using the exact same wording. When necessary new questions were asked and the probes were used to gain more in depth information and extend the discussion on the related topic

Table 7.4.2

Demographic Information of the Interviewees

	Cultural Group	
	TCs	**GCs**
Sex		
Male	8	5
Female	5	3
Range	24-55	20-65
Education Level		
Up to High School Level	2	1
Up to University Level	11	7

7.5 Data Analysis

Data analysis was carried out in accordance to the guidelines provided by Shinebourne (2011) that were highlighted earlier in this chapter. During the first stage of the analysis researcher aimed at familiarising herself with each of the transcripts and it was achieved through repetitive readings of them. This was then followed with researcher taking notes and making observant comments. Researcher mainly focused on making descriptive comments; rephrasing participants, linguistic comments that consisted of considering the words and expressions shown by the participants and conceptual comments that involved considerations of the previous work done in the field as well as her own experiences (See Appendix 9) While making different notes researcher used different forms of underlining to make it easier for her to follow the iterative analysis process. She then moved on to finding the emergent themes referring back to the three forms of notes previously made. At this stage, her focus was shifted into interpreting the data more than just reading it. The themes were generated by mainly focusing on the conceptual notes while also paying attention to the linguistic and descriptive ones. Initially, themes were created in forms of phrases and sentences but then were made more concise (See Figure

7.6.1) as suggested by previous researchers as Smith et al. (2011), Pietkiewicz and Smiths, (2012) and Shinebourne (2014). While being concise researcher also made sure that the themes were inclusive enough for her to remember the original source from which they had been derived from.

Once this process was completed the researcher revised the themes in an effort to identify commonalities amongst them. With the use of the emergent themes as well as the theoretical information she had, researcher created the superordinate themes as listed in Figure 7.6.1. In order to make it easier to follow researcher grouped subordinate themes underneath the superordinate ones chronologically. Further to these, researcher also used her research questions in an effort to organise the themes. Underneath each research question the researcher first noted the superordinate theme/s followed by the subordinate theme/s. She created a Microsoft Word table for each participant's transcript that consisted of the research questions, super and sub ordinate themes corresponding to each of the questions. This process was repeated for each of the participant data that was analysed. At the final stage she started to look at the common patterns across each participant's case. These similarities have acted as a bridge that helped her to pull out the whole picture of the attitudes towards mental illness in Turkish and Greek Cypriot communities and the factors influencing these attitudes.

While trying to bring out the whole picture and giving credit to each participant's perspective researcher had to make some changes to both superordinate and subordinate themes in order for the themes to follow a logical order and create a descriptive story. Thus some of the themes were amended, changed or excluded and in some cases new themes were added as the researcher progressed with the analysis of the new transcripts. At every

stage researcher referred back to the original data that the themes were derived from in order to ensure the suitability and validity of them.

7.6 Data Verification

Qualitative research had received much criticisms particular from the positivist due to its naturalistic nature. This nature meant that, unlike the quantitative research the concepts of validity and reliability are addressed differently in the qualitative phase of the thesis. Guba (2007) had proposed four main criteria that allowed qualitative researchers to assess reliability and validity; credibility, transferability, dependability and confirmability.

Credibility refers to the appropriateness of the measures used in the study for its aims and objectives. Several researchers as Guba (1981) and Lincon (1995) highlighted the credibility as one of the most important aspects in establishing trustworthiness of the findings. Various ways had been introduced that allowed researchers to establish credibility when carrying out a qualitative research. In this part of the project researcher had used the following; objective selection of the participants, tactics that helped honesty of the participants and triangulation. As mentioned in Chapter 4 although participants were selected using a convenience sampling technique, once the quantitative phase was completed researcher had created a list of the participants who volunteered to take part in the qualitative phase. Interviewees were then selected randomly from this list to ensured unbiased selection of the participants. According to Preece (1994) this may also help open up any unknown factors that may influence the credibility of the results by ensuring that these factors are distributed equally within the sample. This also allowed participants to vary by gender, educational level, age as well as occupation, which ensured more of a

representative data to be collected. It is believed that the credibility of the findings had been enhanced as the selection procedure had also ensured that the samples selected from each of the communities were representative of the larger groups under exploration.

Another technique used to ensure credibility of the qualitative work undertaken in this project was the use of triangulation. As mentioned in Chapter 4 the qualitative study was undertaken after the quantitative part has ended in an effort to overcome the shortcomings of each of the techniques. Adopting different techniques allowed researcher to better understand and explain what is considered a complex stigma phenomenon. Particular details in relation to attitudes, stigma, culture, familiarity and knowledge were also obtained from the participants during the qualitative phase, which adds on to the credibility of the study. Furthermore, triangulation via data sources, which meant that the participants' perspectives were compared to each other, was also used. This was done to ensure diversity of the findings that refers to the Dervin's (1984) concept of 'circling' reality. Circling reality is further defined as the benefits of collecting data on a wide spectrum of observations to obtain a more stable perspective of reality. Finally participants were also given the right to refuse or withdraw from the study freely, which meant that only those who were willing to take part and genuinely offer their perspectives were included.

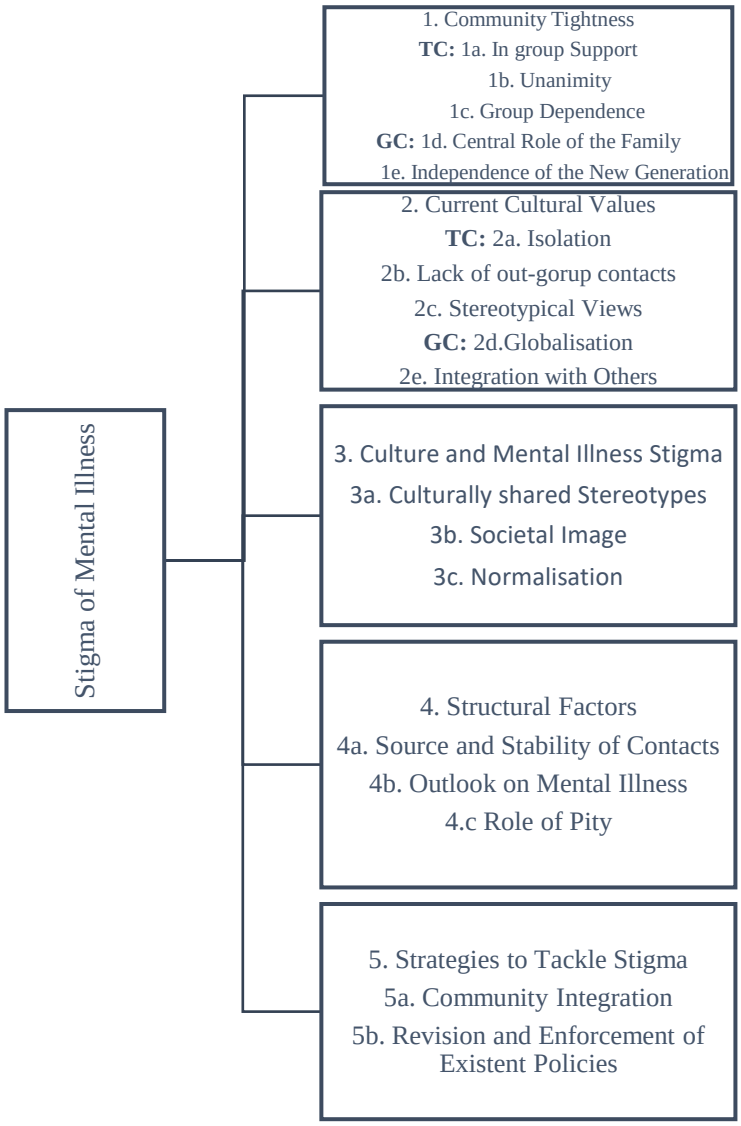
Transferability refers to the extent to which the findings of a particular study can be applied to different situations (Anney, 2014). In an effort to provide transferability of the qualitative study a detailed explanation of the methodologies used (See Chapter 4) as well as the key findings are provided throughout this chapter. It should, however, be noted that although each participant's case is unique in a qualitative study and, therefore, each perspectives should be appreciated individually, these perspectives are also understood as

the examples of the broader groups' perceptions. Transferability, therefore, was made possible by providing a detailed explanation of the mental illness stigma which reflects the individual and groups' perspective that allow readers to gain a full understanding of mental illness stigma consequently enabling them to apply it to their observations.

Dependability refers to the consistency of the findings over time (Bitsch, 2005). An Audit Trail is a common technique used by the qualitative researchers to assure dependability of the data findings (Anney, 2014). An Audit Trail refers to the detailed explanation of the techniques used data collection and analysis. Researcher, therefore, had provided a detailed account of the data collection techniques both in this chapter and Chapter 4. Furthermore, researcher also explained the steps followed to analyse the transcripts earlier in this chapter. In addition to this some of the interview transcripts are also provided for cross checking the inquiry process (See Appendix 9). This had also assured the confirmability of the findings of this study that can be defined as the extent to which other researchers can confirm or validate the results of an inquiry. Further to this as highlighted in Chapter 4, a reflexive account had been given for the qualitative phase of the study which is another way of ensuring confirmability of the results (Bowen, 2009; Koch, 2006; Lincoln & Guba, 1985). In preparation of writing the findings section researcher created a figure that consisted of super-ordinate and subordinate themes derived from the participants' transcripts (See Figure 7.6.1)

Figure 7.6.1

Figural Display of the Superordinate and Subordinate Themes Extracted from Participants'Interviews



7.7 Findings and Discussion

In order to extract the themes Turkish and Greek speaking Cypriot participants' transcripts were compared. As explained earlier in this chapter interviews were analysed and the communalities and differences were noted down amongst these interviews. Initially a list that consisted of the themes from each of the groups was created individually. After

that the common as well as different patterns of the themes were then identified and noted down which allowed researcher to make a comparison between the TC and CG participants' transcripts.

This section of the chapter, therefore, aims to provide a detailed explanation and discussion of the superordinate and subordinate themes derived from the analysis of the data. For this reason the researcher will first start by explaining each of the themes in detail referring to their meaning and providing quotations from the original participants' transcripts to help explain how they were derived and what implications they possibly have on stigmatization of mental illness. This will then be followed up with the discussion of the themes in relation to previous theories and research in the field.

7.7.1 Community Tightness

Considering the findings of the quantitative studies of this thesis (See Chapter 5 &6) as well as the previous research in the field suggest the impact of culture on attitudes towards mental illness (See Chapter 1 & 2) researcher, wanted to explore the cultural structures of the two communities in more detail.

Results of the quantitative study showed that as well as culture impacting on the attitudes towards mental illness and predicting public stigma, Greek and Turkish speaking Cypriot communities also differed in their cultural orientations. Compared to TC (M=7.49), GC report to being individualist although their collectivism levels are also high (M=6.53) displaying similar patterns of those from Eastern Europe (M=6.88) as noted by Öncer (2013).

In order to gain a deeper understanding on the differences between the two communities in regards to their culture and to better understand how these differences may play a role on attitudes towards mental illness, interviews started by asking each participant to define and explain their culture in detail. This allowed researcher to understand each participants' unique perspectives of their culture and the important factors that form and shape the current cultural structure of their society. Community Tightness was, therefore, the superordinate theme that emerged in this section of the analysis.

One of the most important dimensions that help differentiate between cultures is known as the individualism-collectivism dimension (Hofstede, 2001). This dimension is often used when one wants to make distinctions amongst different communities and cultures and explain their differences (Ting-Toomey et al., 1991, Triandis, 1989; Mood, Jonsson, & Låftman, 2017).

Although previous research carried out by Helmreich and Merritt (1998) note Cypriot people as being collectivist in their culture, these studies were mainly carried out with GCs and no recent research was available in the field considering the Turkish and Greek speaking Cypriot communities of Cyprus.

Through the interviews with the TC participants, transcripts were found to mostly include themes such as reliance and ingroup support (Hofstede, 2001). The subordinate themes that emerged from the TC participants transcripts were; 'In-Group Support', 'Unanimity', and 'Group Dependence'.

7.7.1.1 In-Group Support

The initial subordinate theme under the superordinate theme of Tight Knitted Community was "In-group Support" which refers to a high level of dependence and reliance of the TC community members to each other. Interviews with the TC participants revealed that they feel obligated to support each other within their community. A particular reference was made to the centrality of family and familial support that is continuously given; from birth until death.

An interviewee, Mustafa (TC, Public Server, Male, 30), stated the support given to each other by the TC community members "*when you say Cypriot culture the first thing that comes to my mind is our people, support and food of course."* A female participant called Ayse (TC, Accountant, Female, 25) also mentioned the support which TCs give to each other in their society and has noted that *"You know in our community support which people especially families give to each other is very strong. You can be 50 but you still obey your parents. It is a sign of respect."*

Another male participant also emphasised the strong support amongst TCs even towards TCs who are not known to them; Ahmet (TC, Civil Servant, Male, 36) said that *"When you go to someone's house especially in villages if you are a Turkish Cypriot they call you to their house even if you do not know them and they feed you to make sure you do not leave hungry. I love the hospitality we show to each other."*

Cesur (TC, PhD student, Male, 28) also noted the dependence amongst the TC community members but also emphasised on the centrality of the family; *"Family is everything and Cypriots will do anything to make their family members happy. There is a*

great bond between the families and if you need help or anything the first thing you do is to call the oldest member. For example I would do anything for my children to see them happy."

The importance of familial support was further stated by another participant Ugur (TC, Bank Manager, Male, 42) who noted *"In our community if a family member has a problem it is an extremely big deal. Everybody will get involved and try to sort things out. It is because if they do not the problem will continue and you know it will cause even a bigger problem."*

7.7.1.2 Unanimity

Perhaps one of the most obvious distinction between individualism and collectivism is the priority given to one's own personal interest as opposed to the groups' Kolind, Friis Sogard, Hunt & Thylstrup, 2017; Knyazeva , Kuznetsova, Savostyanov & Dorosheva, 2017). Furthermore, as highlighted in previous chapters 2, another important quality of the collective societies according to Triandis (2001) is that people form their identities based on their social network, which they have been part of from birth. This is why group ties and bond is very strong amongst the in-group members in collective cultures (Triandis, 2001). In these societies community members need to consider the needs of others and support them in order to be able to show their loyalty.

Similarly, TC participants also mentioned the importance of group harmony along with sacrificing one's personal interest for the benefit of the group. For example Anil (TC, Cardiologist, Male, 38) that *"In my community it is important to be careful and think about the consequences of your behaviour. If you do not, it is possible that you are going to upset*

others around you and you will be out-casted. So you can never really be free to do what exactly you want to. You have other people to think about."

Cesur (TC, PhD student, Male, 28) stated; *"to us Cypriots, it is important to fulfil the expectations of our society. It is a small community and everybody knows everyone, society in general is curious about your personal life. For this reason you cannot really do what you want. I mean there are certain things that your family expects from you as well as the society. I graduated from high school, did my undergrad then a postgrad [degree] but my parents always wanted me to be a doctor because then I can get a better job and earn more, so now I am doing a PhD. I did not have to, I mean I could still find a job but because it's their wish for me, I could not say no. Even in our society it is like that, a very simple example is now that I am 28 everybody is keep asking me the same question, "When are you getting married?" I am not ready but I started to think about it. So you know how it is, everybody is involved in your life."*

7.7.1.3 Group Dependence

According to Smith, Vignoles, Becker, Owe, Easterbrook, Brown, & Yuki (2016) in order to be able to keep unanimity of the group, members must have a high sense of dependence amongst their own group members in collective societies. They, therefore, argued that 'group reliance and dependence' is predominant due to the strong sense of group membership and a strong bond amongst the group members.

Parallel to this, Aliye (TC, Teacher, 48) a female participant mentioned that *"You know you have to rely one each other to get things done. If you do not get along you cannot*

sort anything out. So we need to be very close and support each other unconditionally to keep everything going."

İlmiye (TC, Teacher, Female, 55) also mentioned the importance of getting along with other members of the TC community. *"I am not sure if there is another country like us. You are a Cypriot like me and you know how things work in here. If you want to get a job you have to know someone, if you want to get things done anywhere like in banks, schools, and governmental places especially it will be much easier for you if you know someone in that particular place". We call this "ahpab işi" which basically means that if I know you I will support you and do whatever you ask me to do. Like the other day I went to get my blood test done at the hospital and their shift normally ends at 12:00pm. But due to work I went there at around 14:00 pm. I spoke to my friend who knew one of the nurses and thankfully she took my blood. In our public hospitals you are supposed to get a number and queue up to be seen even for a blood test. But if you know the doctor somehow may be through someone else or personally you get to be seen first, even without a number.*

From the transcripts of the TC participants it became obvious to the researcher that the particular dependence of the family members to each other as well as the reliance of the group members in the TC community are classified as the unique qualities of their collective culture. Similar to how Hofstede (2011) defined the collectivist society's characteristics, TC participants also report relying on each other more than others in order to solve their members' problems. As such reliance and support seem to ensure unanimity amongst the family and the TC society members. This also ensures order within the society, which helps minimise ambiguity.

In addition to this, particularly in Ilmiye's transcript the vertical orientation of the collective culture came forward. There seems to be more of a hierarchal system within the TC community where people accept the power difference between different members of the society and also see knowing someone powerful as advantageous for their survival.

As mentioned in Chapters 2 and 6 in collective communities as TC social norms and information are determined by the community group members based on the idea of what is 'good' and therefore, how one 'should' behave in order to survive through in-group partnership. These norms are then passed through generations and shared communally within the group members. It has also been noted that the members of the collective communities are more sensitive to social information that have been passed through generations (Oyserman, Coon, & Kemmelmeier, 2002; Triandis, 1999). In order to adhere to these traditionally determined norms, close relationships are formed amongst the group members and those (i.e. Individuals with mental illness) who do not adhere are classified as being deviant and may be out casted.

7.7.1.4 Central Role of the Family

When looked at the GC participants' interviews in relation to the superordinate theme 'Community Tightness', 'Central Role of the Family' emerged as the first subordinate theme. This theme refers to the importance of the family and the strength of the familial bond where family members love and support one another unconditionally. For example when asked to describe what Cypriot culture is like Andreas (GC, Lawyer, Male, 58) stated, *"It is a beautiful culture. We enjoy our time with family, we enjoy our food, to*

drink and dance. But you know it started to change because now people are too busy and we really only have little time to even spend with our family."

Similarly Maria (GC, Civil Servant, Female, 52) also argued *"Well Cyprus culture is different than others. To us family is very important. I have 2 kids who study [away from home] now and if I do not talk to them a couple of times during the day I start to worry. I like to know what is going on in their lives. I want to know that they are ok and if they need my help. They know I am and will always be there for them."*

Michalis (GC, Retired police officer, Male, 65) who lived in the UK for many years and returned to the island 20 years ago made an interesting comparative account as well by stating *"I would say Cyprus culture is about food, family, folk dance and traditions. Although compared to the old times it is changing and people even families are becoming more distant, as a family we still like to get together at least once a week and this gathering generally happens in 'γιαγιά's' (grandmother's) house where she cooks food almost enough for the whole island."*

Traditionally family has been placed at the core of both TC and GC Cypriot communities. While family is still central to either of the communities, transcripts of the GC participants are showing the changing nature of particularly the familial relationship.

7.7.1.5 Independence of the New Generation

Although changing, the importance given to the family members seem to be very similar with TCs. Different than the TC participants, GCs, however, also noted the

changing structure of the society where people especially the new generation are becoming more independent.

For example Prodromos, (GC, Student, Peace Activist, Male, 25) noted that *"I went to Athens to study and when you start living away from your family you get used to it, I mean I love them but I also love being independent. So when I came back to this island I started to rent a house that is in another city than my family. I still go around to see them often but it is my life and I like to control it."*

Anna (GC, Teacher, Female, 28) also mentioned *" I lived with my family until last year. I was a student and they helped me a lot financially and emotionally and I am grateful for that. This year in September I took a job in a primary school and I decided it was time for me to start being a bit more independent. My parents were a bit surprised when I wanted to move but I think they understand. I am always there for them when they need me. I have a place that I can call my own and it feels great. It is like I have my own life now and I am the responsible adult."*

Maria (GC, Civil Servant, Female, 52) also noted the changing structure of the GC community particularly with the new generation becoming more independent *"In the old times you left your parent's house when you got married. Now it is different our kids have their own minds, they do not hesitate to oppose to our ideas, I mean they are not disrespectful but they have different vision from us. My 2 kids are now studying abroad and one of them is graduating this summer so he keeps telling me that he wants to stay in London and travel. It is a nightmare for me as I want them both next to me but you know they are not like us they want to be independent. We used to graduate from school, start*

looking for a job and get married then have kids. Now I do not even know if my children want to get married or have kids they want to live their life but time is passing you know he is 26. I had him when I was 26!"

Andreas (GC, Lawyer, Male, 58) stated, "*Now we send our kids abroad to get education and job and of course when they come back they are different. They become hard to please, they are more independent. When I was a child we used to live in Paphos and my mother did not even send me to Nicosia for schooling because she found it too far. In my time family stayed together and also the neighbours were very close. We knew everyone in where we lived our community was our big family. Now my kids do not even want to go visit their family once a week, they do not know their 2nd-3rd cousins, they are becoming more independent and disconnected from their family. They rather go to a coffee shop and meet with their friends. They have got their own things to do and I mean I do not blame them they need to work and are busy but I miss those days where we used to have a big family gathering, long tables with full of food and everyone together."*

Through the transcripts provided by the GC participants in relation to their culture it is clear that family, particularly the immediate relatives as parents, children and grandparents carry a great importance. Care shown and support given to each other within the family members seem to be very important for GCs. It is, therefore, possible to say that Greek and Turkish speaking Cypriots share some similarities in their cultural practices particularly in regards to the strong familial bond. It, however, also became clearer that particularly with the new generation wanting to be more independent, the cultural structure of the GC society is changing and is becoming more modernised over the time. Thus findings from the interviews support the findings of the quantitative study (See Chapters

5&6). These findings are also in parallel with the previous research done in the field and as discussed in Chapter 2. For example in their recent article Cohen and Varnum (2016) argued that compared to the collectivist societies like China where group cohesiveness and group's goals are more emphasised, in individualist societies being independent, being able to structure and control one's own life carries a greater importance.

7.7.2 The Current Cultural Values

Dwelling more on to the cultural structure of the Turkish and Greek speaking Cypriot communities, another superordinate theme labelled as "The Current Cultural Values" had emerged. This theme refers to the factors that contribute to the maintenance of collective structure within the Turkish and Greek Cypriot societies and its consequences on the societal structures of these communities. The researcher believed that understanding the factors that help maintain the current cultural values of the two communities could enable her to also understand and appreciate the unique and different attitudes towards mental illness found in the two communities of Cyprus. From the transcript that were analysed three subordinate themes were generated in relation to this superordinate theme; "Lack of Out-group Interaction", "Stereotypical Views" "Isolation" for the TC participants and "Globalisation", "Interaction with Out-siders" emerged as the superordinate themes for the GC community.

7.7.2.1 Lack of Out-Group Interaction

Due to a strong sense of dependence and reliance found amongst the group members, collectivist societies tend to be making more precise distinctions between in-group and out-group members (Uskul & Over, 2017). As a result it has been highlighted in previous research that individuals from collective societies may feel threatened and ostracise others from other cultural backgrounds (Markus & Kitayama, 1991; Yuki & Schug, 2012; Uskul & Over, 2017).

Transcripts of the TCs also showed that they were unwilling and more resistant to interact and integrate with others outside their own cultural group. For example Kani (TC, Retired Public Servant, Male, 65) stated that "*Turks came here and they try to change us but we did not accept this. Everybody thinks that we are similar but we are not at all. Their language, their clothing, their food, dance, traditions and the way they behave is so very much different. They do jobs we will never do; they work in low-paid jobs that we would not want to. Even if you pass by their house you will say this house belongs to a Turk not a Turkish Cypriot."* Another participant named Emine (TC, Hair-dresser, Female, 55) also mentioned *"Now we have lots of people coming from outside and it is ok for them to come and work but most of us do not get integrated with them. Even with Turks you know they are all different they are not like us."*

As it could be seen from the interview transcripts of the TC participants a sharp distinction between TCs and others as Turks are being made which is another characteristic that is commonly observed in collective communities (Triandis 1989).

7.7.2.2 Stereotypical Views

This subordinate theme refers to TC participants' views on and perceptions of the people from different nationalities. Analysis revealed that TCs hold stereotypical and judgmental views on those other than their in-group members and they also find it hard to trust what they classify as the "outsiders". This was even evident for the Turkish settlers of the island who had been part of the TC community for a very long time.

In their study Andriani and Sabatini (2014) also stated that due to the qualities of collective societies such as in-group support and cooperation, members of such communities tend to trust and cooperate with people outside their groups less compared to those from individualist societies. They also noted that members of the collectivist societies have a narrower world-view and stereotypical beliefs of others.

For example Cesur (TC, PhD student, Male, 28) mentioned *"We have to be strong within our society because we cannot trust anyone but a Turkish Cypriot; they come to this island settle down and commit to crimes. I am talking about Turks you know those who come here are the ones who do not have jobs, do not have money so what they do is they come here and commit crimes. In old days burglary was unheard of in this island. My father and grandfather tells stories about when they were young where they used to sleep in their garden or "hanay" which is the balcony, they used to not lock their homes or shops at night. They used to be able to do this because they had Turkish Cypriot neighbours"*

Aliye (TC, Teacher, Female, 48) *"When I was a child we used to leave our doors, windows and houses open, I do not remember our house door being locked once. We had Cypriot neighbours and kids used to play outside on the streets for hours, women used to cook together and people just trusted each other. Those days were wonderful.*

Unfortunately for us Cypriots after the 1974 Turkish settlers came and now we are less in number than them and now even people from different nationalities are keep coming. So you cannot trust to let your child out to play because you never know what will happen. We never used to hear crimes on television as burglary, rape or murder but now every day there is something. And people who are committing these crimes are not Cypriots they are mainly Turkish or people from Africa, Pakistan. We live in an era and we cannot trust anyone to even leave our doors open. I am a teacher at a public school and I see kids of the settlers I mean they are different; they are not like our kids. They play different games, talk, and dress and even eat differently. Because they are so different, we do not prefer sending our kids to the public schools now, we do not want them to be influenced. Our people do not trust them and we surely do not want our children to be behaving like theirs so we send them to private schools where most of the Turkish Cypriots attend and the Turkish Cypriot teachers teach."

From the transcripts it seems as if TCs became isolated in their own country where they find it hard to trust those apart from their own kind. This can also be due to the trauma experienced in 1974 (See chapter 3). In his article Somasundaram (2014) argued that the negative influence of war could result in changes to one's cognitive, emotional and social systems. The influences of these negative experiences are enduring and can be passed on to next generations (See Chapter 3). It could, therefore, be argued that in the TC community, many years after the war and invasion the experiences of it is still playing a role which may be negatively influencing how TC community members view the outsiders. This distrust in outsiders seems to be a protective factor of the traditional structure of the TC community, consequently tightening the collectivist nature.

For example Kani (TC, Retired Public Servant, Male, 65) argued that *"I would not rent my shop to anyone but a Turkish Cypriot. I do not trust them about the rent; they come to this island to steal as much as they can before they get deported. They are not like us they do not have a sense of shame. Our people do not do things like this because it is a small society and if such things happen it will bring shame to you as well as your family. That is a big responsibility so you avoid doing things that are not acceptable. For others, it is not like that so they do not care."*

Emine (TC, Hairdresser, Female, 55) *"When I have a Turkish Cypriot customer it is ok but when I get others like Turks I always hesitate. They even haggle for a simple haircut. I mean there is a fixed price for it. It is not that they do not have money; it is that they are cheap and they are liars. They say they do not have money, I mean if you do not have the money then do not ask for the service. They try to save as much as they can. Cypriots will feel ashamed to haggle like this I do not know, we cannot do such things it is seen as rude in our community."*

Akın (TC, Lawyer, Male, 32) *"Now that we have many universities opening up we get many students from abroad, some come here to work and some to study. I am a lawyer so I deal with many crimes. Generally I do not get cases, which have a Turkish Cypriot individual as an offender. Turkish Cypriots are generally the victims and the criminals are those of other ethnic origins who live in this country. You know they can be convicted for anything: from theft to murder. I think in here our culture plays a role. It is a small place I see the same people every day so if let's say I am in debt everyone will know and talk about it. It is not acceptable in our society. For that reason our people are more careful of their behavior but I cannot say the same thing for others."*

7.7.2.3 Isolation

Being isolated from the outside world due to the embargos placed on the TC community by Turkey had been pointed out by the participants as another factor that contribute to the societal structure of the TC community.

For example Mustafa (TC, Public Servant, Male, 30) *"We cannot even go and participate in a sports competition. I mean we have to be competing under the name of Turkish team, which is ridiculous. I play chess professionally and I wanted to go to a tournament in Slovakia last year, I could not because we are an unrecognised state and so I had to register under the name of Turkish national chess team."*

Kani (TC, Retired Public Servant, Male, 65) "*It used to be so different. Now we cannot even do business with the outside world. Our address is stated as Mersin, Turkey not Cyprus! We are not recognised so we have to support each other in order to be able to function.'*

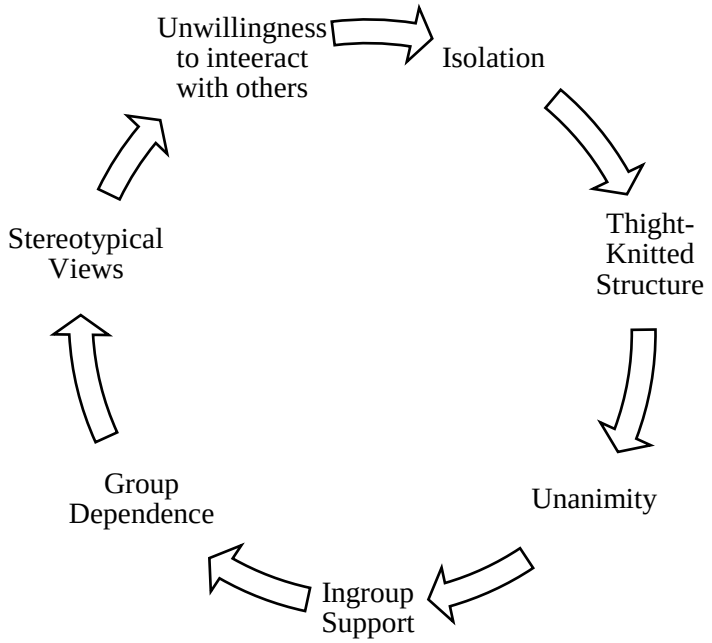
Aliye (TC, Teacher, Female, 48) also noted *"It is ironic that everything we do need to be approved by Turkey, it feels like we are in an open air prison that is being controlled by the Turkish government. Even to fly somewhere other than Turkey our planes have to stop over in Turkey for a certain period of time. We do not have a chance like people from other countries to freely go wherever we want, do business and take part in international platforms because we are an unrecognised state. It is better now that the 'doors' [assigned gates on the 'Green Line' separating the occupied part of Cyprus from the free Republic of Cyprus] are opened and we received the Republic of Cyprus passport but still we have many embargoes placed on us by Turkey that we cannot freely do what we want."*

Emine (TC, Hair-dresser, Female, 55) *"I am old enough to remember the old times in this island where we were not as dependent on Turkey as we are now. We had our own factories, our own schools, our own businesses and farms. Now we do not have any of these, Turkey controls everything and if something is for our benefit they will prevent it by placing an embargo on it. You know even shipping 'Halloumi Cheese' outside the country that is our own product, they put their names and a Turkish address on the package. So in the eyes of the world we do not exist. We cannot do anything because of the restrictions placed on us by Turkey so we try and support each other in this community as much as we can."*

From the interviews with the TC participants it is possible to define TC culture as a traditional one. Although the societal structure has changed over the years with increased immigration particularly from Turkey, it is clear that as a society TCs have kept most of their traditional values unique to their collective culture such as importance they attribute to family and in-groups members. It also seems like the isolated nature of the TC community played a great role in them remaining more traditional (See Figure 7.7.2.4). Further to these the more traditional nature of the community seems to have an effect on how TCs react to their in-group members as well as to those who are foreigners. While there is a great sense of in-group membership and reliance amongst them to each other, outsiders are seen as potential criminals and thus are not trusted. The lack of interaction with outsiders is believed to be further strengthening the collective and traditional nature of the TC community (See Figure 7.7.2.4.).

Figure 7.7.2.4

Relationship of the Factors that Maintains the Collective Nature of the TC Community



For the GC community the Current Cultural Values theme refers to the changes that are taking place in the community in regards to its cultural norms and traditions. It also explains factors contributing to these changes in the GC community. Particular reference was made to the modernisation of the GC society members as a result of 'Globalisation', 'Integration with the Outsiders' as a result.

7.7.2.5 Globalisation

First subordinate theme to emerge was Globalisation, which refers to different cultures influencing each other through immigration, ideas and information exchange and trade (Tate, 2017). An increase in immigration is being seen as one of the main factors influencing globalisation (Tate, 2017). This is because those living in their own native cultures may integrate some of the aspects from the immigrants' cultures into their own. Globalisation and Immigration were mentioned by most of the GC participants who also thought that this was the reason to why they had become more individualist in their culture (This was also addressed in Chapters 5 & 6).

For example Prodromos (GC, Student & Peace Activist, Male, 25) stated, *"It is a different world that we live in now. We can search for anything we want and obtain information so easily with our phones and computers. We are more exposed to different things in world, than our parents were when they were our age. We go, travel, experience and we bring these experiences with us to the island. Like now you see lots of big merchandises opening up. For example now we have many places just like in America and the UK; "Taco Bell, Starbucks and James's Oliver restaurant". World is becoming one and I think we are becoming not Cypriot but more of world persons each day."*

Andreas (GC, Lawyer, Male, 58) also stated *"I think we are changing as a society partly because of globalisation. I mean we have to adapt otherwise you cannot keep up. Now we are integrating more with others, big businesses from all over the world are opening up. You can even go to a supermarket and shop for groceries that are shipped from the UK. So we are now more open, more aware of others and our world in general."*

Charis (GC, Civil Servant, Male, 32) also mentioned how the societal structure is changing as a result of increased globalisation; *"We needed each other more in the old days. I mean we now have access to everything through Internet. Life is easier in general. Everybody has at least two cars per household, there are lots of options for you to choose from when it comes to shopping, eating and making business. So people are living more independently. I do not know if you remember but in the old times we had limited opportunities and so we were more knitted together. For example I remember my parents used to drop me to school and my grandparents picked me up during lunchtime. Everybody used to gather in my grandparent's house to eat during their lunch break then my parents used to return to work. Now children go to nurseries and they are being taken care of by someone else other than a family member. They do not spend as much time with their parents as we did. And also if we want to eat now, we have lots of options so rather than family gatherings we now prefer to go to the shopping malls or restaurants. I think that is mainly why we are less dependent on each other now."*

Maria (GC, Civil Servant, Female, 52) further noted how globalisation simplified the lives of the GCs but weakened the bond amongst the GC community members; *"I remember when I was a child people used to work together in their land at the village and shared whatever they had. People used to do everything collectively. I mean I grew up in Nicosia not in a village but I remember we had to go to the village when it was time to make Cyprus Cheese, "αναρή" (Anari, Cyprus Ricotta Cheese) and everybody in the village used to come and help then we used to share amongst each other. These traditions are fading away nowadays. If I want something I can simply go to a supermarket and buy*

it. It is an easier life but it is making the bond we have with our community members weaker."

7.7.2.6 Integration with the Outsiders

Integration with outsiders was the next subordinate theme to be generated from the transcripts of the GC participants. While all of the participants made a reference to increased immigration on the island (which may be seen as an indirect effect of globalisation) some of the participants reported hesitancy when interacting with those who are not GCs. For example Prodromos (GC, Student & Peace Activist, Male, 25*)* noted *"10-15 years ago you would not see many foreigners in here as you do now. Particularly Asians and Eastern Europeans started to come a lot and they work, study, and marry Cypriots to start their own families. I mean before I used to know my neighbours but now I do not know many of them they are not Cypriots."*

Similarly Anna (GC, Teacher, Female, 28) also stated that Southern part of the island is becoming more 'European and Modern' in its structure and the traditional values are slowly fading away as a result of the EU Membership and Immigration; *"We are changing; before where I lived, everybody knew each other Now we barely talk to each other. Like I remember when I was a child my mother and neighbours gathered every morning to have their coffee and gossip but now people are becoming less and less integrated. I mean they do not have time; women work now and also your neighbour might not even speak Greek. So you have to adapt."*

Some of the participants, however, mentioned the benefits of becoming a member state of the EU and increased numbers of immigration. For example Charis (GC, Civil

servant, Male, 32) stated *"I mean now we have friends from different parts of the world and it is great I think. We talk to them we go out to eat and socialise with them. We are members of the European Union now so it also makes it easier for us to go abroad, see different cultures and meet people other than Greeks."*

Similarly Maria (GC, Civil Servant, Female, 52) also argued *"Now that we are part of the EU we live with others from different countries. Especially in touristic places like Limassol we have many foreigners who made Cyprus their homes. The rate of immigration particularly increased after we joined the EU. They are different than us but for example my children have friends from Russia, Thailand, and Africa. When they come to our house I cook Cypriot food for them. I do want my children to integrate and learn about others. Now that we live with them, they have to."*

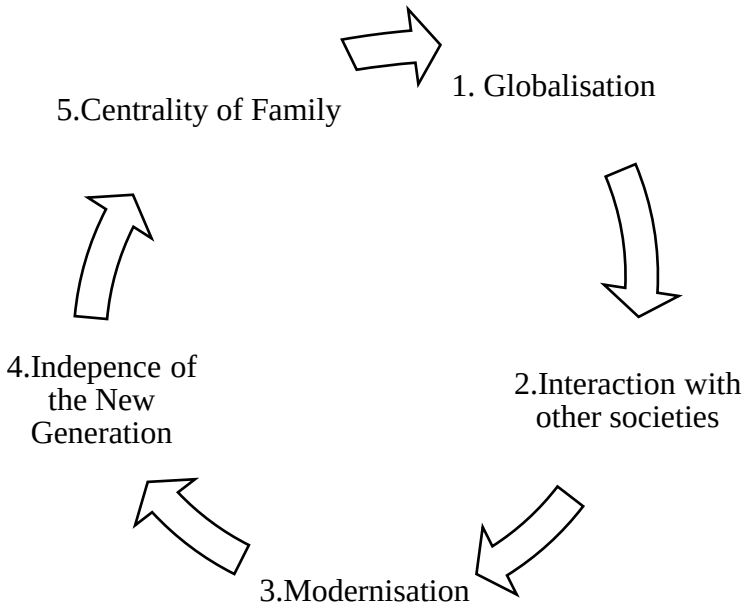
Transcripts of the Greek and Turkish Cypriots have shed a light on the differences in the cultural structures of these two societies who live in a great proximity. The collective structure of the island cannot be underestimated as both societies put an emphasis on their traditional values as well as community support. Particularly family that plays a central role in both of the communities' structures. It, however, also became clear that the GC participants seem more open to having different cultures integrated in their society and have a wider outlook to the world. As discussed in Chapter 2 and earlier in this chapter, previous research done in the field suggests that in collective communities, there is a clearer distinction of "Them" and "Us". This distinction is less certain in countries classified as Individualist (Gorodnichenko & Roland, 2012), which may be why more tolerance is shown to the outsiders in such cultures.

According to Jiaxue (2009) traditionally societies had to act collectively while hunting and other activities in order to be able to protect each other from the outside dangers. As societies became more modern and industrialized overtime, properties of such collectivism slowly faded away. This is because in such societies individuals started to have more economical independence, therefore, were also able to pursue their independent goals (Hofstede, 2001; Triandis, 1995). As a consequence more societies are increasingly becoming diverse and complicated where individualism is at a rise. Previously researchers also noted various reasons for societies' cultural shift from collectivism to individualism (Hofstede, 2001; Triandis, 1995; Allik & Realo, 2004). These include; a) Development in society's economy, b) Individual Wealth, c) Increase in production, d) Immigration, e) Travel and Education and d) Media.

For example to Triandis (1995) globalisation, increased level of education, travelling and mobility leads to more exposure to the outside world and different cultures which is a consequence of the county's economic development. With globalisation GC community had a greater economic development as well as increased rates of immigration, which allowed them to interact with the members of other communities more, compared to the TC community. This interaction combined with globalisation might have made the GC community to become more modernised (See Figure 7.7.2.7). As a result, particularly the younger generation became more independent (See Figure 7.7.2.7). Although centrality of the family is still given a high importance it is clear from the interviews that the more traditional values are fading away.

Figure 7.7.2.7

Relationship of the factors that maintains the modern nature of the GC community



7.7.3 Culture and Mental Illness Stigma

Results of the quantitative study reported in Chapter 5 and 6 showed that members of the both Turkish and Greek Cypriot communities view individuals with mental illness negatively. Significantly higher levels of unfavourable attitudes were, however, reported by

TCs who also reported being more collectivist in their culture and were found to be perceiving those with mental illness more dangerous and threatening compared to GC participants who were found to be more individualist in their culture (See Chapters 5 &6).

With respect to the second research question in regards to the way Cypriot cultural values may influence perceptions of those with mental illness and reasons behind these perceptions, the analyses led to different categories of the themes to be extracted.

7.7.3.1 Culturally Shared Stereotypes

As mentioned in Chapter 2 beliefs about the nature of mental illness are shared amongst the community members, which in turn shape culturally shaped stereotypes that surround mental health problems in societies. These stereotypes are passed through generations and also play a role on attitudes towards mental illness. Researchers as Corrigan, Druss and Perlick (2014) and Stier & Hinshaw (2007) also argued that although stigma of mental illness is a global concept and is experienced by almost all of those who have mental illness, it is an individual experience that takes place between the stigmatized and stigmatizer. Both the stigmatized and the stigmatizer are undoubtedly influenced by their cultural beliefs, values and norms (Markus & Kitayama, 2010). For this reason one cannot overlook culture when trying to understand stigma of mental illness in specific communities.

As mentioned in Chapter 2 the most common stereotypes that surround individuals with mental health problems are dangerousness and unpredictability. Existence of aforementioned stereotypes was also evident in the TC participants transcripts. Majority of the TC participants reported stereotypical beliefs particularly in relation to behavioural issues of individuals with mental illness. These behavioural issues were also noted to be against the norms of the TC community, and, therefore, shown as the reason for stigma and discrimination. Particular references were made to individuals with mental health problems being seen as figures of fun, child-like, irresponsible, unpredictable and dangerous.

For example, Hasan (TC, Lawyer, Male, 33) said that *"it is not spoken because, we as a society find it strange seeing people with unusual behaviour. Because they are acting strange, they are a source of entertainment in our society. People look at them and make fun or treat them badly. It is usually because individuals with mental illness are seen as less able and childlike. You know when a baby learns how to speak they make funny pronunciations so you ask them to say something. With these people it is like that as well. When you see someone acting strange you ask him or her to do things in order to have fun. That is why families prefer not to mention it as well, so that neither the individual nor his/her family become source of entertainment."*

Parallel with this İlmiye (TC, Teacher, Female, 55) also mentioned *"they are a source of fun in our society. You know people call them funny names like crazy, stupid or childlike. I am against it but generally that is what happens. We can say that in our society people have no respect for those with mental illnesses. They see it, as it's the person's fault. Like depression for example they will call you 'nane mulla' which means you over react to*

everything and get upset for no reason. It is almost like society treats them as if it is their fault and they do not understand anything or have no feelings."

Cesur (TC, PhD Student, Male, 28) gave a personal example from his village on how an individual with mental illness gets treated by those around him; *"We have a guy in our village and he is strange. He lives with his mother and his mother has to stay at home to care for him because he is not able to do things on his own. You never know what he is going to do next and you cannot predict him. He is like a moody teenager you know. One minute he is good, comes to the coffee shop and says hi, the next minute he does not talk to anyone and he is aggressive. So people are hesitant to talk to him. When he is on his good day and comes to the coffee shop people ask him to dance or sing and you know he is quite funny he entertains us."*

Similarly Aliye (TC, Teacher, Female, 48) also mentioned how people with mental health problems were perceived as unable to do many things amongst the TC community members; *"People with mental illness in here unfortunately are viewed negatively. It is because of their behaviour, we had a woman who got fired because of this. I do not think anybody will want to work with or give them a job, I mean I wish they did but can you imagine they talk to themselves, they can cry when there is nothing happening and if they do not feel like it they would not come to work. This will damage your workplace so I understand the managers too. I do know that it is hard but if they can only control their behaviour I think people will be more open to give them a chance. I mean you know I am against this and if I was a manager I would hire someone with mental illness but when you look at our society unfortunately that is not the case. '*

Similar stereotypes were also noted throughout the interviews of the GC participants.

Andreas (GC, Lawyer, Male, 58) also argued that *'I think these people still live in isolation and are scared to talk about their condition because they think others will not understand. Sometimes you get really rude people. For example in some supermarkets we have people with different disabilities and they are employed there to pack shopping bags. I do like seeing them do something and I do support it. I even give extra money to them sometimes. But I have witnessed some people refusing to allow them pack their bags. I do not know may be they think that they are not clean or something. It is a shame and I think we need to be more supportive of these individuals."*

Further to these Maria (GC, Civil Servant, Female, 52) also noted, "*When I think about how these people are treated I mean I do not know many but I would say from what I observe that they are not treated as nice as they should be. People can look down to them because they have mental illness. They are seen less capable in our society and get treated like children."*

As discussed previously in chapters 2 and 6, transcripts of the both GC and TC also showed that the negative stereotypes that are shared amongst the community members lead to prejudice and discriminatory behaviour towards individuals with mental illness. Such stereotypes are culturally learned from a small age and they develop as a result of societal norms. There are some expectations from the members of the community and if these expectations are not met stereotypes develop about this group of individuals. The other participants also noted these societal expectations. For example, Prodromos (GC,

Student/Peace Activist, Male, 25) *"Cypriots like to be seen as strong and able to achieve many things. Whenever someone cannot fulfil this expectation they get a label like they are strange, incapable, or weird."*

Chryso (GC, Stay at home mother, Female, 29) *"In Cyprus as women we are expected to do our studies, then get married and take care of our families. Men at the same time need to be able to keep a job and be the breadwinners. I mean it might be changing a bit now but still that is what our society tells us to do. If someone fails to meet the expectations of the society they are automatically labelled and looked down. I think this is why we see people with mental illness less capable and irresponsible. When you look at them they are generally not working and their parents take care of them. In our community after certain age not marrying and living with your parents is not viewed normal."*

Stereotypes have cognitive roots help human brain to categorise in order to save thinking time (Fiske, 2018). They also have affective roots, which suggests that individuals commonly favor their own group and as a result apathy (prejudice) is developed towards those who are from out-group (Nieweglowski, et al., 2018). Both stereotypes and prejudice may lead to discrimination, which is the behavioural component (See Chapter 1). As a result this may lead to unfair actions against the group that is being stereotyped (Matsuda, 2018).

Stereotypes that are the generalisations assume that the members of the certain group share specific traits and behaviour that is predictable (Stephan, 2018). From the interviews of the TC and GC it is understood that the common stereotypes about mental illness are childlike, irresponsibility and inability. These stereotypes are shared amongst

both of the cultural groups. Lack of knowledge about mental illness comes across from the transcripts as most of the participants refer to those who have mental illness as babies who are unable to talk and act properly. It can, therefore, be argued that perhaps these stereotypes exist in both of the communities partly due to lack of knowledge about mental illness which is in a supporting manner to the quantitative studies' findings (See Chapter 5 & 6). It has been argued by the previous research that stereotypes are strengthened when there is an absence of any evidence or correct information that disregards the generalizations (Hilton & Hippel 1996). Considering the efforts in the field of mental illness started only recently in the GC community and the fact that not much effort being spent in the TC community it may be that these communities' members are more prone to stereotyping those who have mental illness. The bad treatment that these individuals are faced with and isolation of them from the community as mentioned in the interviews can be thought as being the behavioural consequences of stigma and discrimination. This shows that stigma exists in both of the communities and as suggested by Corrigan (2001) it is a result of interaction amongst stereotypes, prejudice and discrimination (See chapter 1).

7.7.3.2 The Societal Image

One of the other sub-themes that emerged from the transcripts of both TC and GC participants was the importance of societal image. Starting with the TC participants, transcripts revealed that mental health problems are not spoken out and mainly their families hide individuals with these conditions away from the community. This was particularly due to the fear that such health problems may lead individuals and their families to lose their "good societal image" in the eyes of their community, which in turn will bring stigma to the individual as well as the families (See Chapter 2). For example

Hasan (TC, Lawyer, Male, 33) stated *"Mental illness in Northern Cyprus is not spoken about. I mean people prefer to hide it in our society completely. We know they exist but we do not know who these people are and really what mental illness truly is. I think it is mainly because in our society everyone knows everyone so if something like this is heard everybody will talk badly. So people keep it hidden and do not talk about it at all."*

Another participant İlmiye (TC, Teacher, Female, 55) made an interesting account to why mental health problems were unspoken in the community and to her this was due to such conditions resulting in dishonouring of the individual as well as his/her family. She stated that; *"Well I have not spoken to anyone with such conditions. I do not know where they are we do not have much awareness because such issues are not spoken in our society. It is like if you have it, this will be dishonouring you as a person and also your family so you keep it hidden as much as you can."* A similar account was also made by another participant Mustafa (TC, Public Servant, Male, 30) who further added *"Nobody will understand what is going on with you. If you are seen going to a psychiatrist for example people will talk behind you and your family. They will probably blame you or the upbringing you had; so your family. It is a small society and things like these are heard very quickly. Whatever they do I mean, I think these people try to hide it if they have this sort of issues. That is why they would be even scared to seek help because this type of thing is a source of shame in here."*

Similar issues as mental illness being unspoken due to the fear of damaging their "public image" had also come up in the GC participant's transcripts. For example in her transcript Anna (GC, Teacher, Female, 28) *"Having a mental health problem in our community still viewed negatively. Our people think about such conditions in a very*

different way. It is a small place so these conditions are kept and dealt with inside the family. Otherwise it can damage to the reputation of the family."

Similarly Andreas (GC, Lawyer, Male, 58) stated the unspoken nature of such conditions but also emphasised on the necessity of such attitudes to change; *"Us Cypriots pay too much attention to what other people say about us and our family. To us family is very important so for example anything that I do has a consequence on my own family. Unfortunately because mental health problems are not accepted in our society because they cause problems such conditions are hidden away to avoid damaging family's reputation."*

As noted in the earlier section of this chapter throughout the interviews with the TC participants as well as the GC ones the central role of the family and thus importance given to its togetherness had come forward. Values and norms are, therefore, shaped in an effort to keep particularly the family unit together in these societies. These efforts overtime become rules that are collectively shared. From the transcript of the TC and GC participants it became clear that one way of keeping centrality of the family is by meeting the society's expectations by avoiding immoral behaviour such as couples sharing houses before marriage or women having children before they get marriage, being homosexual or seeing a psychiatrist. In general behaviour such as lack of self-control, unpredictability and inability to provide for the family are seen as immoral. As such behaviours are commonly associated with mental illness (Hofstede, 2001; Papadopoulos, 2009; Seeman, Tang, Brown & Ing, 2016), having a mental health problem is perceived to be a damaging factor to the individuals' as well as their families' reputations. In order to avoid this mental health problems are, therefore, stigmatised and hidden away from the community.

7.7.3.3 Normalisation of Mental Illness

Although negative attitudes and stigma exist in GC community, participants also emphasised on the necessity of such attitudes to change for the benefit of individuals, their families as well as the community. GC participants tend to explain mental illness in terms of a condition that could happen to anyone. For example Chryso (GC, Stay at home mother, Female, 29) stated that "*I feel sorry for these people and I can empathise with them. It is not their fault, it can happen to all of us."*

Andreas (GC, Lawyer, Male, 58) noted that "*I mean mental illness is a different thing, people do not really like to talk about this and do not view it as an acceptable condition to have, like I do not know, like diabetes but this must change.* He also argued that *"I mean it is something that everybody can have, do you see what I mean? I can have it, you can have it. You know we had such a bad time in this island in 1974 and recently in 2013. Lots of people have lost their relatives, their jobs, and their houses so I think in Cyprus everyone has some sort of a trauma because look at our history. It is just some people feel it more so they need help. I try to help these people as much as I can but these things are not really talked about in public freely. I know because I have a close relative with mental illness.'* Following this Andreas was asked how people with mental illness were treated in the Southern part of the island by the public and he replied '*I think it is getting better with time. Like in old times people used to be not so nice about it, they felt ashamed and did not want to even acknowledge that they have someone around them in their families with mental illness. There is still hesitancy and shame that surrounds such conditions but I think now we are more understanding. At least I am and I think it is because we now have more awareness of these issues and also very recently we have had*

an economic crisis where most of us were badly influenced so people can actually empathise more with those going through bad times." Andreas's transcript shows the positive shift on the attitudes towards mental illness in GC community. He acknowledges the fact that troublesome history of the island as well as the recent financial crises has made people become more understanding and tolerant to each other.

This was supported by another participant's transcript as well. Prodromos, (GC, Student, Peace Activist, Male, 25) also noted *"We do not like to talk about it but we have to. This needs to change for our people. I mean it can happen to anyone someday. Especially after what we have been through I think in Cyprus there are lots of people with these conditions. I mean I do not know when I think about 1974 and what happened to us in 2013 I think all of us got affected badly in regards to mental health."*

Maria (GC, Civil Servant, Female, 52) also mentioned how attitudes were changing in a positive way for those with mental illness; "*Like before these things were not talked as openly and these individuals were not seen working or studying but now we have people with such problems in employment and they are capable of doing things."*

In a supporting manner of the quantitative study (See Chapter 6) transcripts of the GC participants, showed that attitudes towards mental illness have started to change in a positive way. Although still not discussed as freely due to the fear of stigma and concerns about societal image, it is clear from the transcripts that GC community became more open discussing mental health and illness particularly after the most recent economic crisis in 2013 that affected many lives in a negative way (See Chapter 3). It could, therefore, be argued that the recent negative experiences that the GCs went through as a whole

community might have increased the discussions about mental health and illness taking place more freely. As well as increasing awareness, this could have potentially also helped the GC community to better understand and empathise with those who have such conditions. In support to this, according to Ho et al., (2016) the more awareness and understanding the individuals gain about mental illness, the more pro-social behaviour they will express, consequently reducing stigma and discrimination of those with mental illness.

7.7.4 The Non-Cultural Factors and Mental Illness Stigma

Once the attitudes towards mental health problems had been identified in TC and GC communities and their link with culture had also been explored, researcher wanted to explore the reasons and consequences behind such attitudes other than culture. At this part of the interviews, participants were asked about the other factors that may be contributing to the attitudes towards mental illness. As discussed in Chapters 5 & 6 the results of Tthe quantitative study showed that there several personal factors, which play a role on attitudes at this section of the interviews the researcher, focused on the role of pity and familiarity on attitudes towards mental illness.

7.7.4.1 Source and Stability of Contact

Source and Stability of Contact emerged as a subordinate theme that referred to the TC and GC participants source of familiarity and frequency of the contact that they have with those who have mental illness. One of the main themes that emerged from the GC participants' transcripts was the stability of one to one contact mainly through work.

Chryso (GC, Stay at home mother, Female, 29) stated "*For example, we had a guy at work where I used to work who was a bit strange but people still tried to support him. We saw him every day so he was a part of our team. When he was not at work people used to wonder where he was and if he was ok. Of course you get people who do not want to have anything to do with these type of people but I would say me and people where I used to work were more understanding."*

Andreas (GC, Lawyer, Male, 58) also argued *"Like I said before in some supermarkets we have people with different disabilities and are employed there to pack the shopping bags. It is good I think because it shows us that they can work ad contribute to the society as well. I think there needs to be more effort put into bringing these people into the community."*

Further to these, Maria (GC, Civil Servant, Female, 52) also noted, "*I work in an office and our tea boy has a disability. We always buy things from him to support him rather than going to a coffee shop. I always try to talk to him when I see him. He lives with his family and says he helps them out with his income which is nice to see."*

As discussed in Chapter 2 familiarity with mental illness is perhaps one of the most commonly researched factors in the field of stigma (Angermeyer, Matschinger, & Corrigan, 2004; Corrigan, Green, Lundin, Kubiak, & Penn, 2001 Rusch, Angermeyer and Corrigan, 2005; Corrigan, Druss, Perlick, 2014; Lyndon, Crowe, Wuensch, McCammon & Davis, 2016). Work done in the field suggests community members who encounter those with mental illness particularly within the social arenas as work report more awareness and understanding about mental illness (Corrigan, 2011; Zieger, et al., 2016). This

understanding helps debunk the myths and stereotypes that surround mental illness. It also enables the community members to empathise with those who have mental illness. This also is in line with Morrison's (2011) study, which reported that nursing students with a direct interaction with those who have mental illness are better, able to empathise with and express more positive attitudes, towards these individuals. In support to this, other studies done with the public also noted that positive feelings could influence attitudes and behaviour towards mental illness and other groups who receive stigma such as those with AIDS/HIV (Decety, Echols & Correll, 2010; Ho, Potash, Ho & Chen, 2016).

The vital role of one to one contact on reducing stereotypical beliefs about those with mental illness such as inability, unpredictability and dangerousness, was evident within the GC participants interviews.

For example Prodromos (GC, Student/Peace Activist, Male, 25) noted that *"I have a friend with major depression, it is hard on him but he manages it well. He finished his PhD and looked for work for couple of years now he has a job and he is doing fine. The other day he wrote it on facebook that he had been battling with major depres sion for a long time, I think it was good so everybody knew why sometimes he was feeling so down. The reactions were quite positive people were putting you know that heart shape symbol in there so I think our people especially the new generation are becoming more accepting of these issues."*

Charis (GC, Civil Servant, Male, 32) also stated how knowing someone with mental health problems personally can help lower stigma as it can help people to normalise these conditions in communities (Whitley & Campbell; 2014; Joachim & Acorn, 2016). He

noted; *"I have a guy at work who has mental illness, they hired him a year after me I think. I got to know him and he opened up about his mental health problems to me. I was really shocked to find it out you know I never suspected it and I think he was also scared that I would judge him but actually I thought well he has this condition and he comes to work, he has no harm to me he is a guy just like me."*

Anna (GC, Teacher, Female, 28) also stated *"I have a family member with mental illness. It was hard for her in the beginning even with the family and how they treated her. You know how parents and grandparents are. To them it brings shame to the person and to the family so you must not talk about these things outside. I remember they even wanted to send her abroad to get a treatment and they would have said she is gone to study. They could not do that so they asked her to stay at home and drop out of school at the time. Thankfully she did not and now she has got a job in a private sector and she is doing ok. It took some time for her to finish school, get treatment and be where she is now mentally but I mean she did it. It is possible for these people to live in the society just like us with the right support and treatment."*

Parallel to these Chryso (GC, Stay at home mother, Female, 28) also noted her personal experience with her husband's condition. In her transcript she talks about how society's and their families' initial reactions were negative but notes the changing nature of these attitudes as their familiarity increased with her husband's condition; *"My husband has mental illness. When I first had our baby he had to be hospitalised because he could not handle it. He lost his job due to the recession and had to stay in a hospital for couple of months and you know everybody judged him as well as me. Some people blamed me and even said that I drove him crazy. It was hard because people even his family turned against*

us. They were mainly blaming him for being weak and me for being very pushy on him. My family helped us after he was discharged from the hospital so he found a job and he is handling it fine now. He still has some days where he does not want to do anything with anyone but at least our life is normal. We still do not talk to his family much but it is getting better and they are now accepting the situation."

Maria (GC, Civil servant, Female, 52) also talked about how over the years familiarity with mental health problems had increased which in turn positively influenced attitudes towards mental illness in GC community; *"The kid had been strange since childhood he used to even hurt animals. He could not go to university because of his behaviour and he was always at home being cared by his parents. I remember I was a child and my grandmother used to say if he comes to speak to you immediately come home. I mean it was not just her, everybody thought he could hurt us kids. His mother was stay at home mum and I do not remember her going to anyone's house to have coffee and you know this is such a well-known tradition amongst our women. Nobody really wanted to get involved with this family because of their kid. He is still at home his mother passed away but he lives with his sister. I think he works in a car garage couple of days in a week. It is good I mean he works, he can support himself and I think people are more understanding towards them now. I mean I am old too but older generation like my mum or grandmother would not understand these issues as much. But like us who grew up with him I think we are better at least we do not run away from him now (laughs)."*

In the GC community there seemed to be an increased level of familiarity where almost everyone who participated was able to give a real life example of one to one contact. Parallel with the findings of the quantitative study (See Chapter 6), participants' transcripts,

however, still reflect the existence of negative perceptions about mental illness especially by the older generation. This may be due to the fact that the efforts to reduce mental illness stigma within the GC community has started in the past 10-15 years so the older generation is less aware and familiar with mental health problems and those with mental illness. Looking at the transcripts participants note that in the old times there was not much awareness and familiarity with mental illness thus stereotypical beliefs were more evident. As a result, people with mental illness were kept away from the society for the fear of stigma. It could, therefore, be argued that the older generation is less aware of mental illness, therefore, are less tolerant to such conditions consequently are more likely to hold negative attitudes towards persons with mental illness (See Chapters 2 & 6). It is clear that people with mental health problems are better able to find jobs, get education and live their lives more independently in their societies, which in turn also increases familiarity with and improves attitudes towards such conditions.

As previously mentioned familiarity can, however, vary in regards to its context, which in turn also influences attitudes towards mental illness (See Chapter 2). It can come through different sources as media, friendship or having someone with mental illness as a family member. Van Dorn et al., (2005) emphasised on the importance of the source of familiarity by arguing that having a friend or a family member with mental illness is more likely to improve attitudes as it reflects the reality about mental health and illness, consequently reducing stigma.

Parallel with this, in this study interviews with the TC participants showed that being familiar through media could in fact worsen attitudes towards individuals with mental illness. For example Ayşe (TC, Unemployed, Female, 25) stated *"Whenever I watch the*

news there is some sort of a criminal act, it is generally followed by the person who committed the crime being mentally ill. You cannot help but think well then those who have mental illness are dangerous criminals."

Cesur (TC, PhD student, Male, 28) also noted "*I do not know if you watched the news but the other day there was this guy who described as being mentally ill living in Famagusta. They said he gets naked and runs around in the neighbourhood in front of kids and women. They moved him away because neighbours were scared and they thought he was going to rape someone. Media made this a big deal it was everywhere and they wrote in big letters guy with mental illness has pushed neighbours to the edge, giving his open name as well."*

Ahmet (TC, Civil Servant, Male, 36) also stated the fact that there is minimal levels of awareness and familiarity with mental illness in the Northern part of the island and it is generally through media; *"Our people do not know what mental illness is because they are not exposed to such things. The only time I think we hear about these people is when there is a crime and we are looking for something to blame. For example we hear violence cases generally from man to woman and immediately you also hear that the person was a drug addict or schizophrenic or has some sort of a mental health issue."*

In support to these findings, Knafo, Schwartz and Armony-Sivan's (2001) study which was carried out in Israel reported that the length and frequency of contact as well as the type of it play a significant role on attitudes towards mental illness. In their study they found that those who have one to one contact for a longer period of time with high frequency also held the least stigmatizing beliefs and attitudes towards individuals with

mental illness. They, therefore, argued that these qualitative properties aforementioned are more important to look for instead of stating whether the person had a contact or not with those who have mental illness.

Another recent study carried out by Ke, Lai, Sun, Yang, Wang, Austin (2015) has found that even one-hour contact in a week with those who have mental illness can effectively reduce negative attitudes and stigma towards these individuals. For the purpose of their study, they recruited 279 students from local schools and administered one-hour classroom session exposing them to people with mental illness and informing them about mental health and wellbeing in general. Results showed that compared to the pre-intervention, during the post-intervention students reported significantly improved attitudes and less desire to be socially distant from those with mental illness. In contrast with Knafo et al.'s (2001) study, this suggests that contact that is less frequent might also lead to a positive change in attitudes. An interesting result in this study was that the students' endorsements of stereotypes were not changed but the attitudes significantly improved. This could be due to the fact that although agreeing with stereotypes can lead to mental health related stigma, being aware of the existing stereotypes about mental illness does not necessarily mean that the person will agree with them, consequently stigmatizing people with mental illness (Ke, et al., 2015).

It could, therefore, be argued that media maintains the stereotypes about mental illness and those with such conditions. Portraying individuals with mental illness as the unbeneficial members of the societies (Smith, 2015) as well as potential criminals strengthens the already existing negative perceptions particularly if media is the main source of contact.

As discussed in Chapter 6 the main source of familiarity was found to be coming through television in the TC community. The interviews carried out with the TC participants are in a supporting manner of this finding. Media in the TC community, therefore, seems to be adding on to the burden of individuals with mental illness (Wahl, 2011) by strengthening the negative stereotypes about mental illness, as "Individuals with mental illness are childlike, dangerous and threatening"

7.7.4.2 Outlook on Mental Illness

The next subordinate them generated was 'Outlook on Mental Illness' that refers to the participants view on mental illness in terms of their capabilities and treatment of mental illness. This directly follows from the previous theme of Source and Stability of Contact as previous research suggests that lack of one to one contact results in higher levels of desire to be socially distant from those with mental illness (Peluso & Blay 2009; Schenner, Kohlbauer & Günther, 2011). Those who report higher desire for social distance are also more likely to support coercive treatments of mental illness (Link & Phelan, 2014). In a complimentary manner of the quantitative study findings (See Chapters 5 & 6), many of the TC participants' transcripts showed that as well as increasing support given to coercive treatment, lack familiarity increased negative outlook on the prognosis and treatment of mental illness.

For example İlmiye (TC, Teacher, Female, 55) from Northern Cyprus noted *"If someone has a family member with such problem for example, they will need to take full control of the individual's lives like treatment, employment, housing, food. If the family member cannot take control then they will go into the hospital in Nicosia so they do not*

have much choice. I cannot imagine a Cypriot family sending their kids to the hospital so they will try to put up with their behaviour first and if it is out control and the person is being violent then I thinks that is when they should send them there."

Hasan (TC, Lawyer, Male, 33) also argued *"Mentally ill do not act normal and that makes people want to distance themselves from such individuals. If they are out of hand they should be put in to hospital to stay there and get treated."*

Ayşe (TC, Unemployed, Female, 25) also noted *"Nobody wants to go near the guy we have in our village because he is mentally ill so I think if it does not go away they need to be put into a hospital because it is only going to get worse. And if it does they can be violent towards others in society."*

Differences were observed between the Turkish and Greek Cypriots in regards to behavioural responses shown towards individuals with mental illness. While hospitalisation and coercive treatment of mental illness were seen necessary by the TCs, medication and community-integrated treatment options were emphasised more by the GCs.

For example Andreas (GC, Lawyer, Male, 58) stated *"I think if they get their treatment and medication regularly they would not be dangerous because medication helps them calm down."* He also noted that *"You know we have a say in Cyprus keep away from normal people they can be dangerous. I think so too; we now have people killing their fathers, neighbours for no reason. I mean because you have a mental illness does not mean you are dangerous and you are criminal look at the news even people who do not have an illness are very dangerous. So I would not say that mentally ill people are more dangerous than those who are not. I would say they need treatment."*

Constantinos (GC, Student/Bar-tender, Male, 20) also noted that *"I do not think they are dangerous they are people just like us. I think it is more like when they have a bad day they may seem distant and so people may think they are irritated so we should keep away. But I do not think they will harm someone knowingly. I know someone with mental illness and she is such a lovely person to be with. I think our community needs to realise that these people are not dangerous and if they get treated they can live a normal life."*

Maria (GC, Civil servant, Female, 52) noted that *"I do think that they are more likely to become frustrated but I think medication will help and also if they know we accept them and treat them nice I do not think they poses more risk than any other human."*

Chryso (GC, Stay at home mother, Female, 29) also stated that "*You hear these things but I do not think they are dangerous. I mean I live with a person with mental illness. He takes his medication and goes to his therapy every week so I think that helps a lot."*

Michalis (GC, Retired police officer, Male, 65) argued *"Well they can be unpredictable so maybe they are more prone to become violent but if they are getting proper treatment I do not think they will be dangerous."*

To Anna (GC, Teacher, Female, 28) *"I think it is also dependent on medication*. A*s long as they are getting treatment and their medication it is ok."*

As it could be seen from the transcripts compared to TCs, GCs are more likely to endorse integrated treatment of mentally ill in their communities. They also put more emphasis on getting the correct for mental illness in order to be able to live independently

in the community. This shows that they have a more positive outlook about mental illness and its treatments.

As mentioned earlier this might be partly due to the fact that in the community of TCs, treatment options are limited where most common way of getting a treatment for mental illness is from a public hospital that does not offer out-patient service. As well as this, there are neither day centres nor psychological services available for individuals with mental illness to get treatment. Those practising in the field of psychology generally receive a four-year basic psychology education, which should not allow them to open clinics, but due to the lack of regulations, they do. This results in people loosing trust towards professionals who should be competent enough to offer treatment for mentally ill and makes individuals with such problems to seek help only from psychiatrists in hospital that is controlled by government.

In contrary, in the GC community there are much more available treatment services with different outpatient-inpatient options for those with mental illness. Thus GC participants are more aware and familiar of different treatment options that are proven to be effective in the treatment of mental illness, which also allows them to carry on living independently in their community.

7.7.4.3 Role of Pity

Further to these the Role of Pity also emerged as a subordinate theme and in line with the previous research pity as one of the most reported feelings which public expresses towards those with mental illness (Corrigan, Bink, Fokuo, & Schmidt, 2015; Fominaya, Corrigan, & Rüsch, 2016). As mentioned in Chapter 6 feelings of pity, however, may

increase stigma associated with mental illness particularly around the perceptions about the coercive treatment. Previous research reported the positive relationship between pity and support given to mandated treatment of mental illness (Dixon, Holoshtiz & Nossel, 2016).

Parallel with this, transcripts of the TC participants showed that those who mentioned pitying individuals with mental illness also supported keeping these individuals under either parental or societal control. For example, Ahmet (TC, Civil servant, Male, 36) mentions public feeling pity towards these individuals who have mental illness and mentions; *"You know people do not want to admit it but I think everyone knows someone with such conditions. For example I know someone who was hospitalised for it. When he came out I did not see him at all it was almost like he got lost. He did not talk to anyone or did not want to go out of his home. I know his mother retired so that she can stay at home with him to care for him. I was his friend and you know I went to see him couple of times asked him if he wanted or needed anything. We gathered money amongst us at work and gave it to him because he lost his job at a bank. I do feel sorry for him his life has turned upside down. He still does not come out much and we do not see him anymore."*

Aliye (TC, Teacher, Female, 48) also stated that *"I like to help as much as I can. I even sometimes go to the hospital to visit them. I do not know them but I feel like that is my duty. They are human beings after all and I feel sorry for them. But that is the only thing that I can do."*

İlmiye (TC, Teacher, Female, 55*) "I mean when families cannot handle them then they are put into the hospitals and I feel sorry for them because they are locked there. Not*

like they cannot go out or something but they are restricted. They have to stay there, I can empathise but that is for their own benefit."

Corrigan et al. (2001) similarly argued that pity can facilitate empathy and compassion, it could, however, also have a negative impact on attitudes towards mental illness. According to them agreeing with thoughts that are pitying, might actually lead one to have an increased 'benevolence stigma'. Benevolence stigma refers to viewing people with mental illness as innocent children who need authoritarian attitude similar to a parent-children relationship (Weiner et al. 1988; Corrigan et al. 1999, Brockington et al. 1993). Previous work done in the field suggest that benevolence stigma may be strengthened by the public's views in regards to mental illness being resistant to treatment as well as people with mental health problems being irresponsible and childlike. Such beliefs in turn may lead public members to think that these individuals should be kept in hospitals in order to be controlled (Corrigan, 2002; Fominaya et al., 2016)

In support to this argument one of the participants gave out her thoughts in regards to persistent nature of mental illness. Ayşe (TC, Unemployed, Female, 25) also noted *"I did not hear anyone recovering from it. I mean I do not know like we have a neighbour who is strange and he has been like that for many years. You do not have an option but to put him in a hospital as his behaviour is disruptive."*

Hatice (TC, Theatre artist, Female, 25) also stated the necessity of such individuals to receive a long-term treatment. *"It is a long process, it is not like a flu that you can address with simple medication. It is complicated it affects your mood, thoughts and*

behaviour everything! So they need to be treated for a long time. I feel sorry and I wish I could help but the best place for them to be is in hospital for their own benefit."

Unlike TC participants, GC ones emphasised helping individuals with mental illness community wise to receive help and support that they need rather than pitying them.

Andreas (GC, Lawyer, Male, 58) *"People say they are dangerous and they cannot keep a job but I think if they get their treatment they can function normally."*

Michalis (GC, Retired police officer, Male, 65) *"As a police officer I dealt with many cases that involved mentally ill. I mean yes they can be dangerous but that is if they do not receive treatment. I had colleagues with such conditions. So I think we must help and encourage these people to seek treatment in order to be able to live normally."*

Anna (GC, Teacher, Female, 28) *"I think if they need to be hospitalised for whatever reason then of course they should but I do not think it is a must. I mean everybody can have it and if one can manage his/her life then I do not see why we should put them in hospitals."*

Maria (GC, Civil Servant, Female, 52) "In our community mental illness is not seen as a positive condition. I mean you can have cancer or other physical illnesses and it is ok people give you lot of sympathy and help for it. But for mental illness that is different as people generally hesitate to talk to you or even come near you! For example I have a colleague who suffers from depression and she told us about it. You know some people at work still hesitate to talk to her but most of us understand and I try to help her by talking to

her often and asking her if she is ok. She takes her medication and sees her doctor often which makes her ok.'

Referring back to Weiner's Attribution Theory (See Chapter 2) it could be suggested that the levels of pity and willingness to help someone will increase if one is not held responsible for his/her condition and if the cause of the illness is attributed to reasons other than personal factors (Obinsawin et al., 2013). The way one helps other can vary from formal interactions to general considerations on that person's wellbeing. On the other hand, if the public members attribute the cause of the illness to personal factors as 'they can control their behaviour', although they may feel sorry for the person they are more likely to have negative feelings as anger or threat. This in turn increases the support of coercive treatment and hospitalization consequently leading higher levels of discrimination and stigmatization of mentally ill within the societies (Obonsawin et al., 2013: Angermeyer & Matschinger, 2003; Corrigan, 2000)

In the case of Cyprus, it is clear that TCs' common perceptions about mental illness are childlike and irresponsible. These perceptions seem to increase feelings of pity along with the support given to controlling individuals with mental illness via hospitalisation consequently resulting in discrimination. Existence of the agreement with such perceptions is lower within the GC participants due to the reasons outlined earlier in this chapter. As a result, GC participants are found to be more likely than the TC participants to engage in helping behaviour as supporting individuals with mental illness to be integrated in their community.

7.7.5 Strategies to Tackle Mental Illness Stigma

Up to this point it became clearer to the researcher that both culture and familiarity play a role on Greek and Turkish Cypriot communities' attitudes towards mental illness. Cultural orientation, values and norms seem to be the reason behind stereotypes about mental illness and individuals with mental health problems. Familiarity also seems to be the moderating factor that helps reduce the public's agreement with these stereotypes. Having more available treatment options that are community integrated seem to play a vital role on increasing one to one contact with those who have mental illness but more importantly to fight mental illness stigma. For this reason GC participants who have higher levels of familiarity mainly through the community oriented approaches to mental illness treatment seem to be reporting lower levels of negative attitudes towards individuals with mental illness. Changes to the cultural structure and social policy within the GC community particularly as a result of gaining the EU membership also seem to be contributing to the positive shift in attitudes towards individuals with mental illness. In the end of the interviews participants were asked to give their thoughts on what could be done to improve attitudes towards individuals with mental illness. Increasing awareness and familiarity as well as enforcing anti-discrimination policies were particularly emphasised by the participants. The superordinate theme of Strategies to Tackle Mental Illness Stigma was extracted from the transcripts. This theme consisted of the following subordinate themes.

7.7.5.1 Community Integration

Community Integration was the first subordinate theme to be extracted. It is concerned with the participants' thoughts as about how community integrated treatments can help reduce stigma towards and discrimination of individuals with mental illness in their communities.

Marina (Student, GC, Female, 20) argued that awareness to mental health conditions need to be increased in GC community; "*We need more awareness, you cannot expect people to learn and accept these things on their own. Cypriot people need to be educated on these issues, you know we are very chilled out if nobody forces us we would not go to the seminars willingly so I think we need to start educating our people in schools, work places and even in hospitals. We need to work together to help these individuals come out and talk about their issues so we can see that they are just like us."*

To Cesur (TC, PhD student, Male, 28) increasing awareness in the TC community was necessary as well; "*We need to organise events in our community just like we do with those who have physical problems where individuals with mental illness can also come and talk about their conditions and also tell us how we can be any help. Professionals need to take more action I mean look at the head of Cancer Disease association Raziye Hanim, she is always in the news organising events bringing awareness and drawing attention to cancer. I have not heard anything about mental illness, I do not even know if we have an association and if we do not I think we should."*

Andreas (GC, Lawyer, Male, 58) argued that increasing familiarity and one to one contact with individuals who have mental health problems was necessary in the GC community; *"I know a person with mental illness so I have a different perspective. I think if we increase interaction then we can help reduce negative attitudes towards these individuals. Because when you see these people on TV it is different you think they are dangerous but when you actually interact with them you see a different side of them. You see that they are not that different than us. We have got lots to do but also our government needs to organise events for this to happen because you know how we are; unless we have*

to do it nobody will bother. I also think that professionals can do more, helping these people is not just giving them medication they can also help change attitudes in societies by trying to draw attention to these issues more."

Chryso (GC, Stay at home mother, Female, 29) also noted that government needs to do more in order to increae awareness and familiarity about mental health problems; "I *did come across to events organised during the mental health day where these sort of events aim to bring awareness to mental health problems. I think they are useful and I think we must have more of them organised. Government needs to take control and help professionals to do such events in our community. I mean Cypriot people are very friendly and I think they are understanding but with mental illness they do not know, they have not got much familiarity so if this can be increased I think our peoples' attitudes will change in a positive way. I have experienced it with my husband even I was hesitant when I found out and wanted to divorce him but he was my husband and we had a kid so I needed to help him. With time I also learnt that it was ok you know it is an illness that can be controlled and he can live a normal life. It is hard and a long process though."*

The TC participants also noted importance of increasing community integration. For example Ahmet (TC, Civil Servant, Male, 36) mentioned that *"These people are hidden away and I think they need to come out so that our people can interact with them. I think if we start getting to know these people on a one to one basis then our attitudes will change and we are going to see the positive side of them."*

Similarly İlmiye (TC, Teacher, Female, 55) also noted the necessity of increasing familiarity with individuals who have mental health problems in the TC community; "*I*

think we must first begin with getting to know these individuals. We must pay attention to who they are?, what they do?, where they live?, and how they live? We need to interact with these individuals. May be go to the hospital and visit them so that we can interact with them. I think if we get to know these people we will be in a better position to make up our own minds about them rather than just relying on media and other people, which can be negative sometimes. I mean Cypriot people are so welcoming it is just that we do not know these conditions well so once we get to know them I think our perceptions and attitudes will change."

7.7.5.2 Revision and Enforcement of Existing Policies

The second subordinate theme to emerge was Revision and Enforcement of Existing Policies. This theme refers to the necessity of improving anti-discriminatory policies mentioned by the TC and GC participants as a step to be taken to reduce stigma in their communities.

Emine (TC, Hair-dresser, Female, 55) mentioned the lack of policy and law enforcement in regards to mental illness; *"I do not know if we have a policy on this issue but you know how our government is even if we do they do not enforce it unless it is for someone that they know. Unfortunately mental illness is still viewed negatively and people do not want to employ these individuals. Especially in this country where qualifications do not really matter and employers will generally hire people that they know or someone they know knows. I do not know how we expect these people to survive without community support. So they end up living dependent to their families or being put into the hospitals. But if we have law against this discrimination I think it will help."*

Hasan (TC, Lawyer, Male, 33) who is also stated that *'We have a policy but it is really old. I mean nobody really takes it into an account so it is useless. I think if we want to improve attitudes we need a new policy on this issue but more importantly our government needs to enforce it. I do not have much hope because you know our government is not really interested in these issues and they will only change the laws to benefit themselves. It is a shame.'*

TC participants reported the fact that there is not a recent policy on mental health and illness. They report lack of trust in their government around these issues while they realise the importance of having such policies and enforcing the law in order to reduce stigma of mental illness.

While TC participants stated the lack of policy and regulation on mental illness as well as lack of enforcement, GC participants stated the existence of policy in the island but lack of enforcement of this policy by government and lack of knowledge that individuals with mental illness have about their rights. Andreas (GC, Lawyer, Male, 58) stated that "*We have policy but I do not know if people obey it really. I myself am a lawyer but I am not sure if we follow it much. Like employers for example nobody can force you to employ someone that you do not want and so employers can show any reason to not to employ mentally ill apart from their illness."*

Constantinos (GC, Student/Bartender, Male, 20) also noted that "*I mean we have a policy and you come across to people in society with mental illness but I think we need firmer regulations and enforcement of them."*

To Maria (GC, Civil Servant, Female, 52) policies and regulations also carry a great importance *"I know there is a policy on mental health but you know Cypriot people they are not like Germans they would not follow rules much so I think there is a need to force things like anti-discrimination laws and regulations in the island. Because we do have a policy that says it is against law to discriminate someone purely on their disability but I do not think our people are really aware of this policy because it is not really spoken about. Governmental organisations need to campaign more, tell people what the law is, educate them about it and enforce the law more."*

Transcripts with both Greek and Turkish speaking Cypriot participants have shown that there is a lack of policy and regulation enforcement in both sides. Particularly in the northern side of the island, due to the mental health policy being out-dated it is not being used and people are not even aware of its existence. In addition to the gaps within the policy, participants also note the negative impact of the lack of advocacy, familiarity and awareness have on the attitudes towards mental illness.

As discussed previously in Chapters 1&2 factors as contact, education and advocacy had been identified as three most promising strategies to reduce mental illness stigma and improve attitudes towards individuals with mental illness within communities (Caldas & Killaspy, 2011). A report produced by the World Health Organisation in 2014 has noted the necessity of establishing firm legislations and policies as well as bringing awareness to mental health and mental illness in order to be able to minimise mental illness stigma within the communities. Livingstone and Boyd (2013) argued that legal action, which involves establishing new laws, amending or replacing the old ones and enforcing them in the communities will help protect the rights of mentally ill individuals as well as reducing

stigma that inevitably affects all aspects of one's life. Such legal action will help people with mental illness to also become aware of their rights and to challenge any forms of discrimination and stigma that they face in their daily lives and also shift societies' perspectives on these issues in a positive way over time.

Szmukler, Daw and Callard (2014) noted that approximately two thirds of the world do not have a mental health regulation or have one, which is more than ten years old so it is not being enforced. Considering the positive impact of having a mental health law as protecting rights of the individuals with mental illness, helping them to get appropriate treatment and bringing awareness to mental health issues and reducing discrimination it is vital for both of the communities to establish, review and enforce the already existing policies on mental health and wellbeing in their communities.

7.8 Conclusion

Throughout the interviews it became clearer that both of the GC and TC societies could be classified as having a collective culture in general where family is in the centre of the both societies and familial dependence is still given a high importance. If individualism and collectivism is thought as a continuum, however, compared to the TC community members, the GC ones can be seen more on the individualist side of this continuum. This is because transcripts of the participants from both sides had shown that those in TC community put much more emphasis on collectivist values previously identified by researchers as Hofstede (2001) and Triandis (1999); community support and reliance, and unwillingness to integrate with others. Compared to the TC participants, GC participants, however, placed much more emphasis on the changing structure of the culture and the fact

that members of the GC community are becoming more independent due to the factors such as becoming a member of the EU, globalisation and increased immigration.

In regards to the perceptions towards those with mental illness and the influence of Cypriot culture on these perceptions, it was found that TC participants reported more negative stereotypes and perceived mental illness as a source of shame and a factor that can possibly damage highly prioritised societal image. GC participants also noted the negative perceptions that exist but they also noted the changing nature of these perceptions in a positive way. To them, this was due to the fact that more efforts are being spent in the GC community to inform and bring awareness to the members of the public about mental health issues. As opposed to this, TC participants argued that due to minimal efforts being spent in TC community to inform and bring awareness to mental health problems, participants were found not to be very familiar with such issues consequently impacting on their attitudes in a negative way.

Finally, when participants were asked about what needs to be done in their communities to positively shift attitudes towards mental illness and help reduce stigma their responses were very similar to each other. Participants from both sides stated the need for government, professionals and NGOs to take more effective actions as enforcing anti-discrimination law and implementing recent policies in this matter as well as informing the public and increasing familiarity. Furthermore, they also argued that there is a need for increased interaction and integration of these individuals into the communities.

In conclusion, it is therefore, possible to say that as expected mental illness stigma exists in both sides of the island and there is a need for strategies to be developed in order

to reduce stigma and change attitudes towards individuals with mental illness. As participants of this research also noted, and supported by previous research carried out in the field, particularly increasing awareness and familiarity as well as establishing firmer policies and regulations around mental health problems will lead to more positive attitudes, consequently lower levels of mental illness stigma. As more efforts are being spent in the GC community in order to reduce mental illness stigma it is possible for the TC community to also revise their actions in this manner and perhaps develop a collective plan to effectively reduce mental health related stigma in the whole island.

Chapter 8: Conclusion

8.1 Introduction

The main aim of this thesis was to investigate attitudes towards mental illness and

those with mental health problems within the Turkish and Greek speaking Cypriot communities of Cyprus. This research also aimed at exploring the reasons behind public stigma and attitudes towards mental illness in these communities. This was done in a hope that the findings included in this thesis will enable policy makers, practitioners as well as the Turkish and Greek speaking Cypriot communities of the island to work together in effectively addressing and diminishing stigma and its negative consequences on those with mental illness. The aim of this chapter is, therefore, to bring both the qualitative and quantitative findings together and discuss the contribution of this thesis to the field as well as its political and societal implications. The limitations of the project will also be discussed in this chapter.

8.2 A Brief Revisit to the Main Findings

This section aims to critically analyse and discuss the main findings of the thesis. In regards to the levels of mental illness stigma findings of this thesis showed the existence of high levels of negative attitudes across the two communities: TC participants M=6.13, GC participants M= 4.57. Four components of mental illness stigma were also extracted from the AQ-27 questionnaire; Threat, Perceived Control, Pity and Hospitalisation. When looked at the reasons behind stigma of mental illness in Turkish and Greek Cypriot participants it was found that some of the demographic factors significantly predicted it; female participants of this study reported higher levels of threat perception while older generation showed more support to hospitalisation of individuals with mental illness. The results of this thesis also showed that knowledge about mental illness was poor in the two communities, however, this was not found to be a contributing factor on mental illness

stigma. Unlike knowledge, however, familiarity levels were found to be significantly differing amongst the two communities and this was a significant predictor of mental illness stigma; TCs reported low levels of familiarity through media. This was related to less favourable attitudes towards those with mental illness. GC reported higher levels of familiarity generally through one to one contact via work or family. This was related to more favourable attitudes towards mental illness. Similarly significant cultural differences were found between the two communities: Greek speaking Cypriots were found to be more Horizontal Individualist while Turkish Cypriots were found to be more Vertical Collectivist in their cultural orientations. Cultural orientation was also a significant predictor of mental illness stigma; those from a more individualist cultural background reported significantly less levels of mental illness stigma compared to those with a collective orientation. Culture was also a significant predictor of all dimensions of mental illness stigma highlighted in this research. In addition to these interviews with the participants also revealed that the out-dated policy, which is still in use within the TC community, was impacting on attitudes towards mental illness in a negative way particularly around the hospitalisation dimension of mental illness. GC community's revised policy that aims to reduce discrimination, on the other hand, seem to be positively impacting on attitudes by raising awareness through encouraging community integrated treatment of individuals with mental illness. Participants, however, mentioned the lack of enforcement of these policies within their communities.

8.3 Early Studies carried out between 1970 and 1990 on the Levels of Mental Illness Stigma in Turkey and Greece

Stigma studies in the field of mental illness within the Turkish and Greek speaking communities started to emerge in the 1970s and 1980s. For example a study carried out in 1994 by Madianos et al. (1999) compared the attitudes of 360 participants from two different boroughs of Athens. The aim of this study was to compare the attitudinal differences of a matched sample of 360 participants drawn from a study, which was carried out in the same area in 1979/1980. The results of the research showed that the participants in the recent study significantly differed from the 1980 study's participants in a positive way on all five factors of the Opinion about Mental Illness scale (OMI); authoritarianism, benevolence, mental hygiene ideology, social restrictiveness, and interpersonal aetiology. The results of this study was attributed mainly to the implementation of local community mental health intervention programmes that were implemented post 1980 in the area which increased public's knowledge, awareness and familiarity with mental health problems. On-going positive shift of the Greek speaking communities' attitudes towards mental illness, were further noted by researchers as Economou et al. (2005) and Papadopoulos (2009) (See Chapters 2 & 6). In 2005 Economou et al. also compared the results of their study that was carried out in Greece assessing public's opinion on schizophrenia with a German (Gaebel et al., 2002) and Canadian (Stuart & Arboleda-Florez, 2001) public. Although Greek participants reported higher levels of avoidance from those with mental illness particularly within the social context, it was found that they were in a favour of having mental health community group homes. Further to these in Papadopoulos et al.'s (2002) study that compared white English and Greek/Greek Cypriots' attitudes towards mental illness it was also found that although Greek/Greek Cypriots living in the UK were more authoritarian towards those with mental illness, they did not differ from White/English participants in

their aggression and benevolence.

The first studies carried out with the Turkish community in the field of mental illness stigma dates back to 1970s. Bayülkem et al.'s study carried out in 1970 across Turkey showed that the public held high levels of negative and discriminatory attitudes. Interpretation of mental illness was generally done by the use of religion and supernatural causes; mental illness was explained in terms of a punishment from God or in terms of person being possessed by a genie. Such beliefs were more evident in rural areas but were also reported in the urban areas of Turkey too. Individuals with mental illness were feared at the time and were perceived as those who were dangerous and unpredictable. For this reason keeping those individuals away from the community via hospitalisation or locking them up in their family homes were seen as normal and necessary practices.

In 1980s and 1990s attitudinal shift towards mental illness, particularly the treatment of mental illness was also reported in Turkey. Studies carried out in the 1990s showed that public had increased knowledge about mental health conditions such as depression and schizophrenia (Arkar, 1990; Arkar 1992; Arkar ve Eker 1994). These studies, however, reported that although public's knowledge had increased, their willingness to avoid from those with mental illness remained the same. It was mentioned in a study carried out by Arkar and Eker (1994) that compared to 1970s, members of the public were more supportive of seeking help from mental health professionals (Arkar, 1990; Arkar 1992; Arkar & Eker 1994). Similarly studies that emerged in 2000s in Turkey showed a further increase in public's knowledge on the aetiology of mental illness as well as the treatment options (Arıkan et al., 2000; Alptekin et al., 2001; Arıkan & Akman, 2002; Aker et al., 2003; Akdede et al., 2004). These studies reported that particularly public's

authoritarian attitudes had lessened over the years when compared to 1970s. They, however, also reported that the Turkish public still holds rejecting, discriminatory and restrictive attitudes towards those with mental illness. Public members particularly seek distance from those with mental health problems within the social context that requires a greater level of intimacy.

The findings of the previous work as well as this study suggests that stigma towards mental illness exists in both Turkish and Greek speaking communities. As mentioned before because there has not been any studied carried out in Cyprus with TC and GC community members there were not much information about the way stigma manifests. The findings of this thesis had contributed to the field by establishing the existence of stigma and it's levels in the respective TC and GC communities. As well as this, factors related to these levels in general and also to each four dimensions of stigma were further investigated to understand the complex nature of it. The next section of this chapter will bring together the findings of this thesis in an effort to show how stigma of mental illness manifests in these two communities and also how the two communities' differences in relation to cultural orientation and societal structure to the variations found on their stigma levels.

8.4 Explanation of Mental Illness Stigma using Collectivist-Individualist Cultural Orientations

Culture was found to be one of the strongest predictor of all four dimensions of mental illness stigma, therefore, it is possible to say that attitudes towards mental illness observed in TC and GC communities can be explained using collectivism and

individualism orientations.

As mentioned in Chapter 7, TC community have been living in isolation since the Turkish invasion of the island. As a result of this isolation TC community members became more reliant to each other making them more collective in their culture (See Chapters 6 & 7). It was also found that TCs were more vertical collectivist which is mainly observed in communities who live in more rural areas that are less developed (Aycicegi-Dinn & Caldwell-Harris, 2013). In such vertically oriented collective cultures there is a greater acceptance to hierarchy and submitting to the demands of the in-group authority figures who are seen as powerful members of the community (Aycicegi-Dinn & Caldwell-Harris, 2013). The themes generated from the transcripts of the TC participants are in line with the values that literature associates with collective communities that have vertical (V) orientation.

In the vertically collective TC community the dependency of the community members to each other is seen essential for survival due to their unrecognised status. (Akkus, Postmes & Stroebe, 2017). It is, therefore, expected from every member of the community to contribute to the community by working and supporting their in-group members. Those who cannot are, therefore, more likely to be excluded from the community. In some case when the treatment for mental illness is not sought early symptoms can worsen which may influence individuals' ability to work and contribute to their communities (Ahmedani, 2011). It could be suggested that in the TC community where there are significant gaps in treatment and prevention of mental illness many individuals may not be seeking professional help until symptoms are no longer manageable. At this stage their ability to work and be productive might be overshadow by their

symptoms which in turn makes them unable to contribute and support their in group members. As a result they may be seen as the weak members of the community and, therefore, discriminated.

Culture and cultural beliefs influence the way community members explain health and illness. This suggests that individuals assess and acknowledge reality based on their sociocultural contexts so the widespread beliefs and values become the person's belief. Such inter-subjective perceptions are likely to be more evident in cultures that are collective as the TC community.

According to researchers as Kapungwe (2010); Çam and Bilge (2013); and Baysal (2013) the traditional explanations and perceptions about mental illness exist in Turkish communities. Parallel with this in his study Cunnigham et al. (2004) also found that the disadvantaged groups, as those with mental illness are more likely to be stigmatised by those who hold rigid and traditional beliefs. For example in Kapungwe's (2010) study mental illness was explained in terms of wrong doing of an individual and his/her family and as a result individual being punished by poor mental health. Similarly in Turkey it is reported that mental health problems can be perceived as a punishment from God but also as a weakness of one's character (Çam and Bilge, 2013; Baysal, 2013).

In support to this, previous research suggests inter-relationship between collectivist values, traditionalism and conservatism (Triandis, 2006; Bush et al., 2008; Papadopoulos, 2009). According to these researchers, such communities are less tolerant to change, and uncertainty hence why they strongly support the traditional beliefs and values that provide them with a structured way of living as well as minimising uncertainty (Jost et al.).

Anything that goes against these beliefs and values is seen as a threat to community's togetherness, therefore, excluded.

Traditional explanations that view mental illness as a weakness of one's character were also more evident in the TC community (See Ilmiye's account in Chapter 7, Section 7.7.3.1). The more collective and traditional nature of the community is believed to be maintaining the continuity of these explanations within the TC community. Because mental illness is attributed to internal causes as personality, there is also a negative outlook on treatability of these conditions. Individuals with mental illness are, therefore, seen as incapable (See Cesur's account, Chapter 7, Section 7.7.3.1) and childlike. They, therefore, believe that these individuals are in need of constant assistance of either their families or the governmental institutions. As well as increasing the levels of Pity, such perceptions also increase the support given to hospitalisation of individuals with mental illness. Looking at the results of the thesis it could, therefore, be argued that the more collective nature of the TC community caused mainly by the isolation that they have been living in for the past 44 years, had led them become more conservative and rigid in their beliefs and perceptions about mental illness. Such rigidity and conservatism was found to be influencing their explanations of mental illness, which had a negative role on attitudes towards mental illness.

With the emergence of Modernization theory in the 1960s (Inkeles, 1966) many proposed the idea that modernisation of a community requires changes in their cultural values towards individualism (Camilleri & Malevska-Peyre, 1997; Hwang, 2005). This theory, therefore, suggests that the cultural differences across the world will lessen as countries develop. One of the opponents to the Modernization theory was Kagitcibasi

(1997) who noted that individuals need autonomy and relatedness regardless of their cultural orientation. To her, development and modernisation of a community will not necessarily mean that cultural differences will lessen but that it will lead to a combination of autonomy and relatedness where obedience to group norms becomes less important than following individual goals in some communities. She, therefore, suggested that modernisation increases individual autonomy but that does not lead to a lack of concern for companionship or close relationships as such relations are necessary for fulfilling the one's psychological needs.

Although it is unclear how modernisation might influence culture of a society, in this study it was found that GC participants did report a shift towards modernisation in their culture (See Chapters 5 & 6). Through the interviews participants mentioned increased modernisation of the community, economical development and globalisation particularly after joining EU. Similar to this studies done in Greece also showed that in metropolitan areas as Athens individualist values were stronger than the collective ones (Georgas, 1989). More recently this was also supported by Mango's (2004) study that suggested more individualist structure of Istanbul (a cosmopolitan city of Turkey) as opposed to other areas of Turkey (particularly the Eastern areas). According to Triandis urban areas support self-sufficiency, which is more in line with the values of an individualist orientation. It should, however, be noted that as Kagitcibasi (1997) suggested cultural shift towards modernisation is not explained in terms of GCs lack of interest to companionship. In fact one of the themes that came very strongly from their interviews was the strong familial bond that they had. They, however, also displayed more desire for autonomy and this is in line with what Kagitcibasi (1997) had suggested.

In relation to attitudes towards mental illness, change in GCs' cultural orientation was found to be partly responsible for the positive shift of their attitudes towards mental illness. The use of more modern explanations of mental illness was, particularly, observed during the interviews with GC participants (See Chapter 7, Section 7.7.3.3). Unlike the TC participants, mental illness was attributed more on to the external factors as economical difficulty, work stress (See Andreas's and Prodromos's transcripts in Chapter 7, Section 7.7.3.3) by the GC ones. It could be argued that increasing modernisation of the GC community had increased interactions (See Chapter 7, Section 7.7.2.6) with out-group members and also the need for autonomy (See Chapter 7, Section 7.7.1.5). Previous research noted that in such communities more liberal and tolerant attitudes towards individual differences are observed (Seligman, 2009). Mental illness is, therefore, not understood as a threat or personality weakness but is explained in terms of psychological and social differences amongst individuals.

As the findings of this research suggested culture plays a vital role in perceptions and explanations that are made by the general public about mental illness. Even in small countries as Cyprus where there are different ethnic groups, understanding the specific community's culture carries a great importance in order to be able to address stigma of mental illness more effectively.

8.5 Explanation of Mental Illness Stigma using Societal Factors: Policy & Familiarity

As well as culture, differences amongst the TC and GC communities in relation to societal factors as familiarity, policy and regulations, efforts being spent around reducing

stigma of mental illness were found to be playing a role on their attitudinal differences (See Chapters 5, 6 & 7).

Particular attention must be given to the differences amongst policy and regulations of the two communities as it is the policy and regulation that determines how much of an effort will be spend to address stigma through increasing public's familiarity and awareness about mental health and illness. As mentioned in Chapters 6 & 7, recent changes made within the GC community's mental health policy had increased the efforts to combat stigma. Since the development of these policies more anti-stigma interventions are being designed, although not perfect there had been a transfer to community-integrated treatment of mental illness, and media is becoming more responsible in portrayal of individuals with these conditions. Interviews of the GC participants had shown that although more policy enforcement is needed, through the establishment of an anti-discriminatory act, public's awareness about mental health and illness had increased over the years (See Chapter 7, Section 7.7.5.2). Particularly adoption of the community-integrated treatment of mental illness allowed individuals to carry on with their daily activities as education and work (See Chapter 7, Section 7.7.4.1). This integration helps public to acknowledge that mental illness can be managed with correct treatment, consequently increasing the positive outlook on the prognosis. It further, signals that individuals with mental illness are capable of working and being a constructive members of their societies just as others, thus they are not to be pitied or isolated, consequently reducing stigma and discrimination of mental illness within the GC community.

As GC public became more aware of the different factors that may influence health through their interactions with those who have mental illness over the years, their

explanations about mental health and illness also started to change. Although traditional explanations of mental illness still exist (See Chapter 7, Section 7.7.3.1), uses of more psychosocial oriented explanations were also evident (See Chapter 7, Section 7.7.3.3). This model argues that mental health and well-being depends on individual experiences, how an one makes sense of these experiences and how he/she responds to them. Thus mental illness may arouse as a result of interactions between psychological and social factors rather than biological or medical ones (Kinderman, 2015).

A recent review carried out by Longdon and Read (2017) showed the positive link between using psychosocial explanations of mental illness and attitudes. In their review they provided an overview of correlational as well as experimental research findings in the field. The correlational research in the field showed a positive relationship between biologically oriented etiological beliefs and stigma levels. For example in Read, Haslam and Magliano's examination of the 22 studies carried out in 14 countries between 1975-2011, it was found that 96% of the results related to the biological model of mental illness were linked to negative attitudes. On the other hand, 92% of the studies that focused on the psychosocial models of illness reported to be linked with the positive attitudes. Another population survey carried out by Pescosolido et al. (2010), which looked at the US population's attitude towards mental illness from 1996 to 2006 showed a positive relationship between the biological explanations of mental illness and social rejection of those with such diagnoses. Further to this experimental research on the field provides additional support to the importance of psychosocial models in reducing stigma. Lebowitz and Ahn's (2014) experiment showed that when the vignettes containing biological explanations about mental illness were used, participants reported less empathetic

responses. Moreover a meta-analysis carried out on the 28 experimental studies by Lvaale, Haslam and Gottdiener (2013) also showed that although biological explanations reduced blame attributed to the individuals, these explanations increase perceived dangerousness and pessimism about recovery.

Overall it could be suggested that changes made in the policy and regulations had been effective in negative attitudes towards individuals with mental illness by integrating them into the GC community and increasing awareness about these issues since 2007. With the enforcement of these policies, however, more could be achieved in terms of stigma reduction.

Lack of these efforts in the TC community, on the other hand, resulted in TC participants to report more agreement with culturally shaped stereotypes about mental illness more. As mentioned the TC community's policy on mental health and illness dates back to 1931 and has still not been revised. In the policy, institutionalised care of mental illness is emphasized which in turn limits the interactions that TCs have with individuals who have mental illness in social arenas. Instead the interaction and familiarity with mental illness come from media, which has been noted as being quite negative and irresponsible in portraying mental illness (See Ahmet's account in Chapter 7, Section 7.7.4.1). As mentioned in chapter 7, public's agreement with stereotypes mediated by media is strengthened when there is no other source of interaction between public and individuals with mental illness.

Lack of community-integrated treatment of mental illness due to policy gaps had also led TC participants to have a more negative outlook on the chances of recovery from

mental illness. In line with this, previous research also noted the negative impact of lack of policy on public's attitudes towards mental illness (Muhamadi et al., 2010). In parallel to this, TC participants of this study knew that it was not the optimal option to hospitalise those with mental health problems but they were unable to identify an alternative treatment, which made them endorse hospitalisation more (See Chapter 6). To them, this was due to government not prioritising mental health and mental illness in their community where open discussions of such issues are discouraged and no recent policy is available. Participants argued that because of this inconsiderate approach of the TC government about mental health, the necessary funding to adopt a more community-integrated approach for mental illness is not allocated.

In line with this, Allport (1954) refers to prejudice as an opinion that is unfavourable and created based on lack of knowledge, irrational feelings and negative stereotypes. To him prejudice could be seen as structuring and ordering social environment via the use of social categories (Tajfel, 1974). This categorisation can create the basis of prejudice, stereotyping and discrimination. In their early work Bewer and Miller (1984) noted that contact could help fight prejudice, stereotype and stigma as it enables de-categorisation. The process of de-categorisation refers to the acceptance of an individual as a unique being rather than a member of a larger group (Gaertner and Dovido, 2000). According to this viewpoint contact allows the in-group (public) and out-group (individuals with mental illness) to get to know each other, which enables the out-group stereotypes to diminish and the in-group bias to reduce (Brewer & Miller, 1984; Miller, Brewer, & Edwards, 1985). This is because while individuals are interacting with each other they focus more on the information about each other that is relevant to individual's self-identity

rather than self as a group membership. Thus they are less likely to use social categories when defining each other. Similarly in the qualitative part of this research several cases of de-categorization done by the GC participants were identified. The use of expressions such as ‘same as us’, ‘like any of us’ and ‘it can happen to anyone’ (See Chapter 7, Section 7.7.3.3) shows the inclusive attitude of the GC participants. Unlike the GC participants none of the TC participants used such expressions during the interviews, which may also be the indication of their discriminating attitudes.

It could, therefore, be argued that as well as culture, findings of this study also showed that societal factors also contribute to public’s attitudes towards mental illness. Increasing one to one contact between public and individuals who have mental illness is, therefore, vital in order to be able to reduce stigma. This, however, requires a wider change in communities’ policies and regulations around mental illness.

8.6 Implications and Recommendations

The burden caused by mental disorders on communities as well as individuals with mental illness and their families have been discussed in the previous chapters (See Chapters 1&2). Overall mental disorders prevent the development of other health strategies and contribute to poverty commonly influencing the poor (Funk, Drew & Knapp, 2012). Adopting and integrating effective mental health policies and regulations, therefore, carry a great importance for the benefit of individuals with mental illness and the society in general.

Stigma of mental illness generally results in the underestimation of mental health and illness by the ministers and the public. This in turn results in lack of funding and

resources to be allocated to mental health and well-being. Further to these, institutions designed to care for those with mental illness decay without the necessary funding and they generally become the last point for exclusion of those with mental illness, when in fact they should be used to aid social inclusion.

Findings of this thesis showed that mental health and illness is greatly under-prioritised within the more collective TC community. Without an effective policy individuals with mental illness are currently receiving higher levels of stigma, which possibly impacts on every aspect of their lives. Existence of mental health policy seems to have reduced stigma of mental illness to a certain extent within the GC community particularly by increasing the public's awareness and familiarity with these conditions. Stigma of mental illness, however, still remains as a major problem for the individuals with mental health problems as well as the communities of Cyprus.

This section of this chapter will, therefore, look at the political, social and the public implications of the results and give appropriate suggestions to help fight and minimize mental illness stigma in both of the Turkish and Greek speaking Cypriot communities of Cyprus.

8.6.1.1Government

A. Policies

-The National Policy Components

- Revision of the TC community's policy and an establishment of a recent one on mental health and illness are urgently needed. Policy should particularly be addressing the discrimination and stigmatization of those with mental health problems in different arenas of life such as employment and education.
- Policies should be encouraging individuals with mental illness to be integrated into their community particularly through schools and work.
- Enforcement of the anti-discriminatory policies is needed in the GC community where government takes a stricter approach when dealing with discrimination cases of individuals with mental illness.
- There is currently no policy that addresses issue around the promotion and prevention of mental illness within the GC governmental policy for mental health. This needs to be given a priority and added to the policy.
- Regular review of the policies and regulations is needed within the two communities in order to further implement necessary strategies to minimise and erase stigma of mental illness in their respective communities but across the island as well.

-The National Policy Process

- Both the TC and GC government should aim to target the key groups such as landlords and employers, who potentially have a significant impact on the lives of individuals who live with a mental health condition.

- It is also important to understand the current situation, needs and demands of

the individuals living with mental illness. This will help make the necessary changes or adjustments in the current policy, increase the quality of care and treatment services as well as the outcomes.

- TC and GC governments need to make an effort to take the views of the current service users, as they will be the ones to be affected by the current policies and strategies. They will also have personal experiences that can shed a light into the strengths and weaknesses of the current systems adopted by the TC and GC governments consequently allowing them to overcome the challenges through policy change and implementation.
- An overall mission statement must be developed by the GC and TC governments in order to be able to set specific goals and targets, which will allow them to tackle stigma of mental illness. This can be done by identification of the key agencies that are aware of the local issues such as educational services, governmental institutions as care homes and prisons, and working with them to set targets and implement the necessary frameworks into the specific communities to combat mental illness stigma.
- There needs to be a regular review of the progress of the implemented strategies and interventions within the two communities that use the variety of outcome measures. For example in order to ensure that the policy which is designed to give equal opportunities to those with mental illness in employment is enforced, there could be an annual monitoring of the existing employees, the applicants and the hires for the new jobs.

B. Resources

-Identification of the priorities

- It is necessary for both of the communities to start identifying their priorities given to the financing for developing mental health system in their respective communities. It should, however, be noted that each of the communities are at a different level in regards to the development of their mental health systems. For this reason they have different priorities and barriers when trying to tackle these priorities.
- The Greek Cypriot community has an established mental health system so perhaps the major finance priority relates to transferring the resources from hospitals to currently used community services. As the funding grows new regional mental health systems need to be designed to fill in the gaps with new resources.
- The Turkish Cypriot community, on the other hand, lacks an effective mental health system so the main priority should be to develop an effective mental health infrastructure. This should include the development of legislations, action plan and the budget related to the proposed actions. Funding could be obtained from the donor organisations such as the EU aid programme for the Turkish Cypriot community**.**
- Governments of the both communities should also provide more funding for the interventions to be designed to reduce stigma and improve the treatment facilities. This will encourage people to talk about their mental health issues consequently increasing public's awareness and willingness to seek help.

-Health System Organisation

- Available resources need to be identified and certain responsibilities need to be allocated in order for the proposed actions to be completed. Timetables need to be created for monitoring and evaluation of the systems in both of the communities.
- Awareness in regards to the possible treatment facilities and services need to be increased in both TC and GC communities.
- Monitoring of the quality of service delivered is necessary particularly during the beginning and at the end of individual treatment.
- Particularly families, religious services, NGOs, housing services, vocational services, peer-support services, and self-help services need to be involved in the organization of the health system.

-Research

- More scientific studies are needed within the different communities of Cyprus in the field of mental illness and stigma in order to be able to develop effective interventions and monitor their impact on public's attitudes.
- These studies should have a representative sample and should look at those who stigmatize and also the experiences of those who are being stigmatized. This will provide much-needed information for the anti-stigma interventions to be designed across the island.
- Future research should use designs that can evaluate the implemented interventions. For example Randomised Controlled Trials that measure behaviour over time and

can spot the behaviour change and long-term effects of the interventions can be carried out.

- Periodic assessment of the attitudes and discrimination of individuals with mental illness at a national level is also needed. This is particularly important in order to identify the strengths and weaknesses of the national and community based campaigns, which aim to target attitudes that are stigmatising towards mental illness.

8.6.2 The Public

A. Employers

- Employers of the GC community should be more sensitive to Equal Treatment in Employment and Occupational Law. This law does not exist in the TC community and needs to be implemented to ensure that individuals with mental illness are given equal opportunities at work and are not stigmatised.

- Employers of the both communities must revise pollicises, which will help promote physical and mental health at work place.

- Employers, particularly the company directors and managers must use initiatives to increase their own awareness about mental health and mental illness.

- Employers must increase communication about mental illness across the organisations are needed to reduce fear, shame, discrimination and stigma.

- Companies can benefit from anti-stigma training such as the Stigma Free training given by the National Alliance on Mental Illness. Such training initiatives aim to help employers to learn and appreciate the ways they can talk about mental health and illness at work place.

These training programs should include;

1. Learning to use correct language when talking about mental illness.

2. Learning to see individual as a whole rather than only seeing his/her condition.

3. Discussions about the ways which employers can support those with mental illness by making the work environment inclusive.

B. Families

- Families play a key role in caring for their relatives with mental illness in both TC and GC community. For this reason it is important to give appropriate help and support to the family members in order for them to be able to effectively care and manage their relative's condition.

- Families can also play a key role in encouraging relatives to seek early treatment. For this reason they should be made aware of the available treatment options and importance of seeking professional help early.

- Due to the stigma attached to mental illness, it can be difficult for families to be open about their needs for support. This is particularly the case for families from the TC community where mental illness is stigmatised to a greater extent. There is a

need for family support groups to be established within the Turkish and Greek speaking Cypriot communities of Cyprus where families can share their experiences, seek advice and receive the much-needed support from professionals, other families and the general public.

C. Individuals

-Individuals who live with a mental health condition

- Individuals with mental illness need to be given the appropriate support to overcome shame and to seek professional help. This is particularly important, as the notion of shame was evident in both of the communities.

- Peer support services that are currently being used in the GC community can also be established in the TC community where individuals with mental illness can share their experiences, receive support from those with similar experiences.

- Establishment of more Self-Help services that work 24/7 such as the Samaritans in the GC community is needed where individuals with mental illness can be given support, advice, tools and techniques that can help them to take control of their lives.

- Individuals with mental illness must be encouraged to come out and share their experiences about mental health and illness within the TC and GC communities. It needs to be acknowledged that coming out about one's mental health problems may raise a dilemma in communities where stigma of mental illness is severe. Although disclosing mental health status may have negative implications, those who disclose

generally report lower levels of self-stigma, increased levels of self-esteem and personal empowerment and a better quality of life.

- Programs as the Coming Out Proud (COP) could be used to aid resolving the aforementioned dilemmas. Such programs focus on providing a strategic framework in regards to advantages and disadvantages of disclosing, the most constructive way to disclose and creating a meaningful personal narrative (Corrigan and Lundin, 2012). These programmes aim to give individuals who have lived experiences of mental illness training about how to share these experiences with the public.

-General Public

- In order for mental illness stigma to be addressed collectively a multifaceted approach needs to be adopted. This approach should involve various interventions designed for specific ethnic groups as Turks, Greeks, Armenians, Maronites and Jews of Cyprus.
- More community-based campaigns that mainly focus on increasing one to one contact are needed in the GC community. Establishment of these programs in the TC community is also vital as they are likely to play a key role in reducing stigma towards those with mental illness within the both Turkish and Greek speaking Cypriot communities of Cyprus.
- Both of the TC and GC communities need to investigate factors, which motivate public to voluntarily take part in these interventions in order to ensure their effectiveness.

- Targeting key groups such as landlords and employers, who potentially have a significant impact on the lives of individuals who are living with a mental health condition.
- Exploring issues around the participation of the older generation in mental health interventions are needed. Care homes, Local coffee shops which older males spend their time during the day as well as the local schools that carry out activities for elderly, churches and mosques can be used to carry out anti-stigma campaigns for the older generation.
- Evidence shows that levels of public stigma vary according to a disorder. For example people with schizophrenia are seen as more dangerous compared to those with anxiety disorder. Stigma and discrimination associated with certain disorders should be addressed specifically.
- TC and GC community members need to be further educated about mental health and different mental health conditions. Education is believed to be an effective way in addressing negative stereotypes about mental illness and those with mental health problems. This education should particularly focus on the following;

1. What is mental health and illness?
2. Myths and Facts about mental illness.
3. What can be done when someone is showing the signs of mental illness?
4. Who to speak to and where to seek help?
5. General treatment of different mental health problems.

- Intensive contact strategies need to be used particularly in the TC community and within the older generation in order to increase awareness to mental health and illness. These contact strategies need to be social which refers to hearing first-voice testimonies from those who have a lived experience of a mental illness.

D. Religious leaders

- In some cases religious leaders can be the first source of help and advice for those with mental illness and their relatives. Cooperation between the religious leaders and mental health professionals is, therefore, important. This is because such cooperation is likely to enable religious leaders to encourage individuals to seek help from the professionals.
- Religious leaders can also be the marshals of religious teachings that help prevent public members from discriminating and stigmatising of those with mental illness.

8.6.3 Service Providers

A. Private-Professionals

- Mental health facilities in the government set-up are limited in quality and quantity in both TC and GC communities. Due to this, private practitioners and hospitals

provide most of the communities' mental health care. For this reason private healthcare providers should take a leading role in raising awareness on mental health and illness by informing the public about these issues in their respective communities.

- Unlike the local services, private settings can be used by everyone who lives in Cyprus. For this reason it is particularly important for professionals working at a private setting to be trained in order to be competent when dealing with individuals from different cultural backgrounds.

- Fees of the private services for the treatment of mental illness are often high generally ranging from 50-100 Euros per visit in both of the TC and GC communities. Considering the minimum wage in the GC community is 924 Euros and 250 Euros in the TC community, high charges for treatment may be a barrier for seeking help on time particularly for those who cannot benefit from the government funded facilities. In order to be able to encourage more patients to seek help and increase awareness about mental health problems treatment fees need to be reduced in both of the Cypriot communities.

- The postponed universal health coverage plan needs to be implemented in the GC community that will encourage individuals to seek help earlier.

- Recruitment of more mental health care professionals are needed in both of the communities to meet the demand and promote mental well-being.

B. Public-Professionals

- There is a lack of trust in the treatment offered by the public services particularly in the TC community. Monitoring of the treatment facilities and the quality of care given in those facilities are needed in order to overcome mistrust between the community members and public health care providers.

- There is a significant lack of public treatment services available in the TC community where only one hospital is dedicated for the treatment of mental illness. There is also no day care or community integrated treatment services is available. Establishment of more public services is therefore needed in the TC community in order to raise awareness within the community to mental health and illness. This will also encourage more individuals to seek help.

- Long waiting lists and lack of quality care may be discouraging for individuals from either of the communities to seek help from the public services. There needs to be a better management of the waiting times in the government funded treatment services. An agreement on local waiting time standards can be set. There needs to be a regular review of the waiting lists to ensure that they are not exceeding the standard waiting time and are up to date.

- Routine monitoring and assessing the mental health outcomes and increasing the workforce training and coordination across different service providers will improve the quality of mental health care within the public settings

- A bi-communal group of mental health professionals can be formed in an effort to fight mental illness. Such groups can help prevention of mental illness and increase public information.

- Bi-communal groups funded by the government can organise local meetings, seminars and information sessions to increase public's awareness on mental illness and fight stereotypes that surround mental health problems within the wider Cypriot community

C. NGOs

- There are currently no NGOs in the TC community, efforts, therefore, needed to be spent to form such organisations that can develop initiatives and give public members an opportunity to come in contact with those who have mental illness.

- The sustainability of the several NGOs dedicated to mental illness that exist in the GC community must be ensured. Increased communication and cooperation between the Ministries of Health and the Ministries of Labor and Social Affairs is, therefore, needed.

- NGOs established in the GC community are usually responsible for organising leisure time activities for individuals with mental illness. Such activities carry a great importance, as such initiatives are possibly the only way for those who have mental illness to socialise and be integrated into the community.

- In order to financially support NGOs in both of the communities more charity events can be organised, various volunteers could also be used to help with administration and fund raising. For example medical, psychology, nursing and social work students can be employed as volunteers to care for those with mental illness in return for work experience.

- Partnership between the NGOs and other volunteer organizations in either side of the island is needed in order to help expand the continuum of mental health care in community setting.

D. Media

- The mass media have an important role to play in educating the public and influencing attitudes. Therefore, they should report mental illness in a fair, objective, and informative manner.

- Many individuals increasingly use social media such as Facebook, Twitter and YouTube, particularly the younger generations. Such resources can be used in the communities to spread information and combat incorrect knowledge about mental illness that results in stereotype and prejudice consequently discrimination and stigma.

- It is important for the social media resources to adapt to local cultural norms of TC and GC communities in order to be most effective.

- Mass media can be used to de-stigmatise those with mental illness in either of the communities and achieve population level attitudinal change.

- The use of first person narratives may help increase awareness, empathy and compassion towards those with mental illness at a population level.

- Messages should be delivered via the mass media about social inclusion and human rights in order to reduce prejudice within the TC and GC communities.

8.7 Limitations of the Study

Although this thesis has several implications and contributions to the field it is not free from limitations. Perhaps one of the most important criticisms of this thesis is the use of term 'mental illness' without any specification. Previous research suggested that different types of mental health problems are perceived differently and, therefore, attitudes can also vary from one another (Speerforck et al., 2017). Considering the fact that low levels of knowledge was found in both GC and TC communities about mental illness, it could be argued that perhaps when they were filling in the AQ-27 questionnaire or being interviewed they thought of a specific disorder as schizophrenia which has been identified as a condition that receives the highest levels of stigma (Lien et al., 2016).

The second criticism could be the choice of using Triandis's INDCOL questionnaire in order to assess culture. Although with his study Triandis noted that the tool is satisfactory, there are not many studies that have previously tested its level of reliability. It should also be noted that the Mental Health Literacy tool developed by Jorm et al. in 1997 could be seen as a relatively old tool, thus use of a more recent and well-established tool could have been advised when assessing mental health literacy. It could also be said that using five different questionnaires that took approximately 20-30 minutes to complete could influence the way participants respond to the questions. They could have felt tired by the end of the questionnaire consequently influencing their answers and the reliability of the results. It could, therefore, be advised for future researchers to use shorter versions of the tools that display sound psychometric properties.

It may have also been beneficial to carry out a pilot qualitative study to test the

interview questions and also enable researcher to investigate emerging themes further. It could have been possible for example to further study factors as modernisation, societal image, and gender roles if the researcher had piloted the qualitative interview. Another improvement could have been made by cross-checking the themes that emerged during the interviews with the participants themselves to refine the findings and establish more thorough and objective explanations. Respondent validation, therefore, could have improved the accuracy of the qualitative findings.

Further to these investigation of trauma which both TC and GC communities endured during the ethnic conflict and its' impact on the attitudes towards mental illness could have been beneficial as previous work research done in the field suggest that having traumatic experiences as war may impact on one's attitude towards mental health problems. This thesis could have also benefited from the investigation of the recent traumatic events which TC and GC communities had experienced; increased isolation and economic crisis. Moreover lack of investigation of mental illness stigma in relation to religion could be considered as another limitation of this project. Previous research note that common religious beliefs about the cause of mental illness include moral weakness, sin or infidelity to the religious commitments as praying or reading the Holly book (Hartog & Gow, 2005; Trice & Bjorck, 2006). Such beliefs are shown to be impacting on public's attitudes towards mental illness as well as help-seeking attitudes of those who have mental health problems (Mathison, 2016).

Moreover use of a qualitative study before the quantitative one could have been beneficial for the researcher to study a complex construct as stigma. This would have helped the researcher to better identify the variables to be used in the quantitative study

consequently enabling these variables to be tested. Future research should pay attention to this and perhaps conduct a qualitative study before the quantitative one. Although for the reasons discussed in Chapter 4, it was not deemed possible in the case of this thesis use of a random sampling strategy instead of a convenience sampling technique could have been more beneficial. Use of a random sampling strategy allows researchers to make generalisation of their study findings. Unlike this, convenience sampling is more limited in regards to the generalisation of the study findings especially with a small sample size. For this reason future research should try to use random sampling techniques in order to make their results more generalizable particularly if they are going to recruit a small number of participants. Finally carrying out some of the interviews in English, which was not, the participants' native language could have prevented them to explain their thoughts and ideas clearly. The researcher could have had a translator but because she could not assess the quality of the translations she preferred to carry out the interviews in English. In order to enhance the quality of the interviews it is ideal for the future researchers to carry out the interviews in participants' native languages. Perhaps training could be given to the interviewer who is going to carry out the interviews so that the researcher could assure the quality of the information obtained as a result.

8.8 Brief Conclusion

This is the first study to be carried out with Greek and Turkish Cypriot communities living in Cyprus that examined public attitudes towards mental illness and stigmatization of those with mental health problems. It is the first time that a study had highlighted societal and cultural differences between the two Turkish and Greek speaking Cypriot communities.

It, therefore, marks the first attempt to measure and establish the levels of mental illness stigma in the island.

It further provides evidence to the impact of cultural orientation particularly the vertical-horizontal-individualism-collectivism orientations of Greek and Turkish speaking Cypriot communities on their attitudes towards mental illness.

To researcher's knowledge this is the most extensive and inclusive study to be conducted that showed the impact of demographics, familiarity and culture on attitudes towards mental illness consequently stigma of persons with mental health problems in Cyprus.

This study brings hope for individuals with mental illness from both of the communities, their families as well as the public. Findings of this thesis can help take more effective steps in reducing and diminishing mental health-related stigma. Considering the societal, clinical and political implications of this research, it can also help minimise the negative impact of mental health related stigma on individuals as well as their communities.

References

Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. *Clinical psychology review, 31*(6), 934-948.

Adonis, M., Karekla, M, & Constantinou, M. (2007). Psychology in Cyprus. *Psychology International, 18* (5), 16

adore Newman, I., Ridenour, C. S., Newman, C., & DeMarco Jr, G. M. P. (2003). A Apology of Research Purposes and Its Relationship to Mixed Methods.S. *Handbook of mixed methods in social & behavioural research*, 167.

Ahmedani, B. K., Belville-Robertson, T., Hirsch, A., & Jurayj, A. (2016). An Online Mental Health and Wellness Intervention Supplementing Standard Care of Depression and Anxiety. *Archives of psychiatric nursing*, *30*(6), 666-670.

Ahn, H. (2017). Seoul Uncle: Cultural Conceptualisations Behind the Use of Address Terms in Korean. In *Advances in Cultural Linguistics* (pp. 411-431). Springer Singapore.

Ajzen, I., & Fishbein, M. (1980). Understanding attitudes and predicting social. *Behaviour. Englewood Cliffs, NJ: Prentice-Hall*.

Akdede B.B., Alptekin K., Özden S., et al. (2004). Gençlerde şizofreniyi damgalama düzeyi. Yeni Symposium 42, 113–117.

Aker T., Özmen E. & Ögel K. (2002) Birinci basamak hekimlerin şizofreniye bakıs¸ açısı. *Anadolu Psikiyatri Dergisi 3*, 5–13.

Akgün A. & Tiryaki, S. A Forgotten Promise: Ending the Isolation of Turkish Cypriots.

Allik, J., & Realo, A. (2004). Individualism-collectivism and social capital. *Journal of cross-cultural psychology*, *35*(1), 29-49.

Allport, G.W. (1954). The nature of prejudice. Reading, MA: Addison- Wesley.

Al Sayah, F., Majumdar, S. R., Williams, B., Robertson, S., & Johnson, J. A. (2013). Health literacy and health outcomes in diabetes: a systematic review. *Journal of general internal medicine*, *28*(3), 444-452.

American Academy of Family Physicians. (2004). *Preparticipation physical evaluation*. McGraw-Hill.

Anagnostopoulos, F., & Hantzi, A. (2011). Familiarity with and social distance from people with mental illness: Testing the mediating effects of prejudiced attitudes. *Journal of Community & Applied Social Psychology*, *21*(5), 451-460.

Anastasiou, H. (2002). Communication across conflict lines: The case of ethnically divided Cyprus. *Journal of peace research*, *39*(5), 581-596.

Angermeyer M, Beck M, Deitriech S, Holzinger A (2004). The Stigma of Mental Illness: Patients' Anticipations and Experiences. International Journal of Social Psychiatry 50, 153–162.

Angermeyer, M. C., Carta, M. G., Matschinger, H., Millier, A., Refaï, T., Schomerus, G., & Toumi, M. (2015). Cultural differences in stigma surrounding schizophrenia: comparison between Central Europe and North Africa. *The British Journal of Psychiatry*, bjp-bp.

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: a review of population studies. *Acta Psychiatrica Scandinavica*, *113*(3), 163-179.

Angermeyer, M.C., Holzinger, A., and Matschinger, H. (2009). Mental health literacy and attitude toward people with mental illness. A trend analysis based on population surveys in Eastern part of Germany. *European Psychiatry, 24, 225-32.*

Angermeyer, M. C., & Matschinger, H. (2003). The stigma of mental illness: effects of labelling on public attitudes towards people with mental disorder. *Acta Psychiatrica Scandinavica*, *108*(4), 304-309.

Angermeyer M, and Matschinger H (2005). The stigma of mental illness in Germany: a trend analysis. *Int J Soc Psychiatry,* 51, pp. 276–284

Anglin, D. M., Link, B. G., & Phelan, J. C. (2006). Racial differences in stigmatizing attitudes toward people with mental illness. *Psychiatric Services*.

Apfel, R. J., & Simon, B. (2000). Mitigating discontents with children in war: An ongoing psychoanalytic enquiry. *Publications-Society for Psychological*, *11*, 102-130

Aphroditi, Z. (2010). Stigma related to help-seeking from a mental health professional. *Health Science Journal*, *4*(2).

Aracena, Y. (2012). Psychosis in Films: An Analysis of Stigma and the Portrayal in Feature Films.

Arboleda-Florez J, Stuart H: From sin to science: fighting the stigmatization of mental illnesses. *Can J Psychiatry* 2012, 57(8):457-463.

Arıkan, K., & Akman, B. (2002). Akıl hastası karşısında kullanılan savunma mekanizmaları ve stigmatizasyon. 9. *Ulusal Sosyal Psikiyatri Kongresi, Malatya,* 212-217.

Arıkan K, Çetin G, Uysal Ö ve ark. (2000) Farklı kültürel ortalama göç stigmatizasyonu etkiler mi? D*üşünen Adam, 13*(4): 222-224.

Arikan K, Uysal O & Senocak M., et al. (2000). The influence of ınformation on social and occupational outcome in mental illness on the attitudes of students in Turkey. *Isr J Psychiatry Relat Sci, 37*(4): 320-325.

Arkan B, Bademli K, Duman A.Z (2011) Attitudes of Health Professionals towards Mentally ill. 10 Year Review of the Literature in Turkey . *The Psychiatrist*; 3:214-231.

Arkar, H. (1991) Akıl hastasının sosyal reddedilimi. *Düşünen Adam*, *4*(3): 6-9.

Arkar, H. (1992) Akıl hastalıkları ile ilgili tutumlar: Deneyim ve psikopatoloji tipinin etkisi. *Turk Psikiyatri Derg, 3*(4): 243-248.

Arkar, H. & Eker D (1992) Influence of having a hospitalized mentally ill member In the family on attitudes toward mental patients in Turkey. *Soc Psychiatry Psychiatric Epidemiol, 27*: 151-155.

Arkar, H., & Eker, D. (1994). Effect of psychiatric labels on attitudes toward mental illness in a Turkish sample. *International Journal of Social Psychiatry*, *40*(3), 205-213.

Arkar H & Eker D (1996) Akıl hastalıkları ile ilgili tutumlar: Verilen neden tipinin etkisi. *Turk Psikiyatri Derg, 7*(3): 191-197.

Arkar H & Eker D (1998) Akıl hastalıkları ile ilgili tutumlar: Psikiyatri stajının etkisi. *3 P Dergisi, 6*(4): 263-270.

Armstrong, G., Kermode, M., Raja, S., Suja, S., Chandra, P., & Jorm, A. F. (2011). A mental health training program for community health workers in India: impact on knowledge and attitudes. *International journal of mental health systems*, *5*(1), 1.

Arnault D, Fetters MD. (2012). "R01 Funding for Mixed Methods Research: Lessons Learned from the "Mixed-Method Analysis of Japanese Depression Project" *Journal of Mixed Methods Research,* 5(4):309–29.

Alexander, L., & Link, B. (2003). The impact of contact on stigmatizing attitudes toward people with mental illness. *Journal of Mental Health*, *12*(3), 271-289. Alexander, L., & Link, B. (2003). The impact of contact on stigmatizing attitudes toward people with mental illness. *Journal of Mental Health*, *12*(3), 271-289.

Alonso, J., Angermeyer, M. C., Bernert, S., Bruffaerts, R., Brugha, T. S., Bryson, H., & Vollebergh, W. A. M. (2004). Prevalence of mental disorders in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychiatrica Scandinavica*, *109*(s420), 21-27.

Aruna, G., Mittal, S., Yadiyal, M. B., Acharya, C., Acharya, S., & Uppulari, C. (2016). Perception, knowledge, and attitude toward mental disorders and psychiatry among medical

undergraduates in Karnataka: A cross-sectional study. *Indian Journal of Psychiatry, 58*(1), 70.

Avruch, K. (1998). *Culture and conflict resolution* (Vol. 31). US Institute of Peace Press

Babbie, E. (2015). *The practice of social research*. Nelson Education.

Barke A, Nyarko S, Klecha D (2011) The stigma of mental illness in Southern Ghana: attitudes of the urban population and patients' views. Soc Psychiatry Psychiatr Epidemiol 46: 1191–1202. doi: 10.1007/s00127-010-0290-3

Bassey, M. (1995) *Creating Education through Research: A Global Perspective of Educational Research in the 21st Century*. BERA England: Moor Press.

Baum, F. (1995). Researching public health: behind the qualitative-quantitative methodological debate. *Social Science & Medicine, 40*(4), 459-468.

Baumann, A. E. (2007). Stigmatization, social distance and exclusion because of mental illness: the individual with mental illness as a'stranger'. *International Review of Psychiatry, 19*(2), 131-135.

Baysal, G. Ö. D. (2013). Damgalanma ve ruh sağlığı. *Arşiv Kaynak Tarama Dergisi*, *22*(2).

Bayülkem, F., Şirin, G., Kasatura, İ., & Başta, O. (1970). Toplumumuzun ruh sağlığı konusundaki görüşmelerini yansıtan istatistiksel bir araştırma. 6. *Milli Nöropsikiyatri Kongresi, İstanbul*, 366-372.

Batson, C. D., Ahmad, N., & Lishner, D. A. (2011). 39 Empathy and Altruism. *The Oxford handbook of positive psychology*, 417

Bell, E., & Bryman, A. (2007). The ethics of management research: an exploratory content analysis. *British Journal of Management*, *18*(1), 63-77.

Benz, C. R., & Newman, I. (2008). *Mixed methods research: Exploring the interactive continuum*. SIU Press.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative research, 15*(2), 219-234.

Berger, J. L., Addis, M. E., Reilly, E. D., Syzdek, M. R., & Green, J. D. (2012). Effects of gender, diagnostic labels, and causal theories on willingness to report symptoms of depression. *Journal of Social and Clinical Psychology, 31*(5), 439.

Betancourt, T. S., McBain, R. K., Newnham, E. A., & Brennan, R. T. (2015). The intergenerational impact of war: longitudinal relationships between caregiver and child mental health in postconflict Sierra Leone. *Journal of child psychology and psychiatry.*

Betton, V., Borschmann, R., Docherty, M., Coleman, S., Brown, M., & Henderson, C. (2015). The role of social media in reducing stigma and discrimination. *The British Journal of Psychiatry*, *206*(6), 443-444.

Bjørkelo, B., & Macko, M. (2012). The stigma of reporting wrongdoing at work: When doing right is perceived as wrong. *Polish Psychological Bulletin*, *43*(2), 70-75. Chicago.

Black, M. (May 10, 2002). The 5 C's: Areas to consider for making your health messages accessible to a wider population. Ontario Health.

Blumner KH, Marcus SC. Changing perceptions of depression: ten-year trends from the General Social Survey. Psychiatr Serv. 2009;60:306–312.

Boardman, J. (Ed.). (2010). *Social inclusion and mental health*. RCPsych Publications.

Boatswain, T. (2005). *A Traveller's History of Cyprus*. Interlink Books.

Blumner KH, Marcus SC. Changing perceptions of depression: ten-year trends from the General Social Survey. Psychiatr Serv. 2009;60:306–312.

Boardman, J. (Ed.). (2010). *Social inclusion and mental health*. RCPsych Publications.

Boatswain, T. (2005). *A Traveller's History of Cyprus*. Interlink Books.

Bornik, Z. B., & Dowlatabadi, H. (2008). Genomics in Cyprus: challenging the social norms. *Technology in Society*, *30*(1), 84-93.

Bos, A. E., Pryor, J. B., Reeder, G. D., & Stutterheim, S. E. (2013). Stigma: Advances in theory and research. *Basic and Applied Social Psychology*, *35*(1), 1-9.

Brewer, M. B., & Miller, N. (1984). Beyond the contact hypothesis: Theoretical perspectives on desegregation. In *Groups in contact* (pp. 281-302).

Brewer J, Hunter A. (1989). *Multimethod Research: A Synthesis of Styles*. Newbury Park, CA: Sage

Brewer J, Hunter A. (2006). *Foundations of Multimethod Research: Synthesizing Styles*. Thousand Oaks, CA: Sage

Brockington, I. F., Hall, P., Levings, J., & Murphy, C. (1993). The community's tolerance of the mentally ill. *The British Journal of Psychiatry*, *162*(1), 93-99.

Broome, Benjamin J. 1996. *Exploring the Greek Mosaic: A Guide to Intercultural Communication in Greece*. Yarmouth, Maine: Intercultural Press.

Brouwer, M. M. L. (2009). Different images of the same past. The institutionalisation of historical narratives in Cyprus as reflections of Turkish-Cypriot and Greek-Cypriot nationalisms

Bryant, Rebecca and Papadakis, Yiannis, eds (2012) Cyprus and the politics of memory: history, community and conflict International library of twentieth century history.

Brynen, R. (2006). 4 Perspectives on Palestinian repatriation. *Palestinian Refugee Repatriation: Global Perspectives*, *2*, 63.

Buizza C, Schulze B, Rossi B, Ghilardi and Pioli (2007). The stigma of schizophrenia from patients' and relatives' view: A pilot study in an Italian rehabilitation residential care unit. Clinical Practice and Epidemiology in Mental Health doi:10.1186/1745-0179-3.

Bunting, B. P., Ferry, F. R., Murphy, S. D., O'Neill, S. M., & Bolton, D. (2013). Trauma associated with civil conflict and posttraumatic stress disorder: evidence from the Northern Ireland study of health and stress. *Journal of traumatic stress*, *26*(1), 134-141.

Burke, P. J., Stets, J. E., & Pirog-Good, M. A. (1988). Gender identity, self-esteem, and physical and sexual abuse in dating relationships. *Social Psychology Quarterly*, 272-285.

Bury, T. (2005). Developmental articles primary health care and community based rehabilitation: implications for physical therapy. *Asia Pac Disabil Rehabil J*, *16*, 29-61.

Byrne, P. (2001). Psychiatric stigma. *The British Journal of Psychiatry*, *178*(3), 281-284.

Cáceda,R., Nemeroff, C. B., & Harvey, P. D. (2014). Toward an understanding of decision making in severe mental illness. *The Journal of neuropsychiatry and clinical neurosciences*.

Caldas, J. M., & Killaspy, H. (2011). Long-term mental health care for people with severe mental disorders. *European Union Publication*, 5.

Campaign, A. (2001). Results of a Global Advocacy Campaign.

Campbell, D. T., & Fiske, D. W. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. *Psychological bulletin*, *56*(2), 81.

Canadian Institute for Health Information, & Canadian Population Health Initiative. (2004). *Improving the Health of Canadians. Summary Report [electronic Resource]*. Canadian Institute for Health Information.

Caracelli, V. J., & Greene, J. C. (1993). Data analysis strategies for mixed-method evaluation

designs. *Educational evaluation and policy analysis*, *15*(2), 195-207.

Carlin, A. M., Tyburski, J. G., Wilson, R. F., & Steffes, C. (2002). Prophylactic and therapeutic inferior vena cava filters to prevent pulmonary emboli in trauma patients. *Archives of Surgery*, *137*(5), 521-527.

Casey, K. (1995). The new narrative research in education. *Review of research in education*, 211-253.

Catani, C., Jacob, N., Schauer, E., Kohila, M. & Neuner, F. (2008) Family violence, war, and natural disasters: a study of the effect of extreme stress on children's mental health in Sri Lanka. *BMC Psychiatry*, **8**, 33.

Chan, C. M., Cao, T., & Gao, M. T. (2015). Chinese conception of mental illness: a comparative culture analysis.

Chan, J. Y., Mak, W. W., & Law, L. S. (2009). Combining education and video-based contact to reduce stigma of mental illness:"The Same or Not the Same" anti-stigma program for secondary schools in Hong Kong. *Social science & medicine*, *68*(8), 1521-1526.

Chandra, A., & Minkovitz, C. S. (2007). Factors that influence mental health stigma among 8th grade adolescents. Journal of Youth and Adolescence, 36(6), 763-774.

Chaudhry, T. (2016). The Stigma of Mental Illness in South Asian Cultures

Charles, C. M., & Mertler, C. A. (2002). *Introduction to educational research* (4th ed.). Boston, MA: Allyn & Bacon.

Charmaz, K., & Henwood, K. (in press). Grounded the- ory in psychology. In C. Willig & W.

Stainton-Rogers (Eds.), Handbook of qualitative research in psychology. London: Sage.

Cheon, B. K., & Chiao, J. Y. (2012). Cultural variation in implicit mental illness stigma. *Journal of cross-cultural psychology*, *43*(7), 1058-1062.

Cherryholmes, C. H. (1992). Notes on pragmatism and scientific realism. *Educational researcher*, 13-17.

Chung, K.F., Chen, E.Y.H. & Liu, C.S.M. (2001). University students' attitudes towards mental patients and psychiatric treatment. Interna- tional Journal of Social Psychiatry, 47(2), 63 – 72.

Ciftci, A., Jones, N., & Corrigan, P. W. (2013). Mental health stigma in the Muslim community. *Journal of Muslim Mental Health*, *7*(1).

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N.& Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological medicine*, *45*(01), 11-27.

Cloutier, M., Aigbogun, M. S., Guerin, A., Nitulescu, R., Ramanakumar, A. V., Kamat, S. A., &

Cohen, L., Manion, L., & Morrison, K. (2000). Research Methods in Education [5 th edn] London: Routledge Falmer. *Teaching in Higher Education*, *41*.

Cohen, A. B., & Varnum, M. E. (2016). Beyond East vs. West: social class, region, and religion as forms of culture. *Current Opinion in Psychology*, *8*, 5-9.

Collins, K. M., Onwuegbuzie, A. J., & Sutton, I. L. (2006). A model incorporating the rationale and purpose for conducting mixed methods research in special education and beyond. *Learning Disabilities: A Contemporary Journal*, *4*(1), 67-100.

Cook, J. E., Purdie-Vaughns, V., Meyer, I. H., & Busch, J. T. (2014). Intervening within and across levels: A multilevel approach to stigma and public health. *Social Science & Medicine*, *103*, 101-109.

Cook, T. D., & Reichardt, C. S. (Eds.). (1979). *Qualitative and quantitative methods in evaluation research* (Vol. 1). Beverly Hills, CA: Sage publications.

Cooper-Patrick, L., Gallo, J. J., Gonzales, J. J., Vu, H. T., Powe, N. R., Nelson, C., & Ford, D. E. (1999). Race, gender, and partnership in the patient-physician relationship. *Jama*, *282*(6), 583-589.

Corbin, J. M., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative sociology*, *13*(1), 3-21.

Cornaglia, F., Crivellaro, E., & McNally, S. (2012). Mental Health and Education Decisions. London: Centre for the Economics of Education, London School of Economics.

Corrigan, P. W. (2000). Mental health stigma as social attribution: Implications for research methods and attitude change. *Clinical Psychology: Science and Practice*, *7*(1), 48-67.

Corrigan, P. W. (2016). Lessons learned from unintended consequences about erasing the stigma of mental illness. *World Psychiatry*, *15*(1), 67-73.

Corrigan, P. W., Bink, A. B., Schmidt, A., Jones, N., & Rüsch, N. (2015). What is the impact of self-stigma? Loss of self-respect and the "why try" effect. *Journal of Mental Health*, 1-6.

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, *15*(2), 37-70.

Corrigan, P. W., Edwards, A. B., Green, A., Diwan, S. L., & Penn, D. L. (2001). Prejudice, social distance, and familiarity with mental illness. *Schizophrenia bulletin*, *27*(2), 219.

Corrigan, P. W., Green, A., Lundin, R., Kubiak, M. A., & Penn, D. L. (2001). Familiarity with and social distance from people who have serious mental illness. *Psychiatric services*, *52*(7), 953-958.

Corrigan, P. W., & Kosyluk, K. A. (2014). Mental illness stigma: Types, constructs, and vehicles for change.

Corrigan, P. W., & Kleinlein, P. (2005). The Impact of Mental Illness Stigma.

Corrigan, P., Markowitz, F. E., Watson, A., Rowan, D., & Kubiak, M. A. (2003). An attribution model of public discrimination towards persons with mental illness. *Journal of Health and Social Behaviour*, 162-179.

Corrigan, P., & Matthews, A. (2003). Stigma and disclosure: Implications for coming out of the closet. *Journal of mental health*, *12*(3), 235-248.

Corrigan, P. W., Morris, S. B., Michaels, P. J., Rafacz, J. D., & Rüsch, N. (2012). Challenging the public stigma of mental illness: a meta-analysis of outcome studies. *Psychiatric services*, *63*(10), 963-973.

Corrigan, P. W., & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, *57*(8), 464.

Corrigan, P. W., Sokol, K. A., & Rüsch, N. (2013). The impact of self-stigma and mutual help programs on the quality of life of people with serious mental illnesses. *Community mental health journal*, *49*(1), 1-6.

Corrigan P, Thompson V, Lambert D, Sangster Y, Noel JG, Campbell J. Perceptions of discrimination among persons with serious mental illness. Psychiatr Serv 2003;54:1105–1110.1

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice*, *9*(1), 35-53.

Corrigan, P. W., Watson, A. C., Warpinski, A. C., & Gracia, G. (2014). Implications of educating the public on mental illness, violence, and stigma. *Psychiatric Services*.Mestdagh, A., Hansen, B. (2014). Stigma in patients with schizophrenia receiving community mental health care: a review of qualitative studies. Social Psychiatry Epidemiol (2014) 49:79-87.

Coker, E. M. (2005). Selfhood and social distance: Toward a cultural understanding of psychiatric stigma in Egypt. *Social Science & Medicine*, *61*(5), 920-930.

Cothren, C. C., Osborn, P. M., Moore, E. E., Morgan, S. J., Johnson, J. L., & Smith, W. R. (2007). Preperitonal pelvic packing for hemodynamically unstable pelvic fractures: a paradigm shift. *Journal of Trauma and Acute Care Surgery*, *62*(4), 834-842.

Cotton, S. M., Wright, A., Harris, M. G., Jorm, A. F., & McGorry, P. D. (2006). Influence ofgender on mental health literacy in young Australians. *Australian and New Zealand Journal of Psychiatry*, *40*(9), 790-796.

Couture, S., & Penn, D. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of mental health*, *12*(3), 291-305.

Coxon, A. P. (2005). Integrating qualitative and quantitative data: What does the user need? Forum: Qualitative Social Research (FQS), 6(2). Retrieved May 2005 from http://www.qualitative-research.net/fqs-texte/ .

Creswell, J. W. (1998). Qualitative inquiry and research design: Choosing among five designs.

Creswell, J. W., & Clark, V. L. P. (2007). Designing and conducting mixed methods research.

Crisp, A. H., Gelder, M. G., Rix, S., MELTZER I. H, and ROWLANDS J. O. (2000). Stigmatisation of people with mental illnesses. British Journal of Psychiatry 177, 4-7.

Crisp, A., Gelder, M., Goddard, E., & Meltzer, H. (2005). Stigmatization of people with mental illnesses: a follow-up study within the Changing Minds campaign of the Royal College of Psychiatrists. *World psychiatry*, *4*(2), 106-113.

Crocker, J. (1999). Social stigma and self-esteem: Situational construction of self-worth. *Journal of Experimental Social Psychology*, *35*(1), 89-107.

Crocker, J., Major, B., & Steele, C. (1998). Social stigma. In. DT Gilbert, ST Fiske, & G. Lindzey. *The handbook of social psychology*, *2*, 504-553.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process*. Sage.

Crouch, M., & McKenzie, H. (2006). The logic of small samples in interview-based qualitative research. *Social science information*, *45*(4), 483-499.

Çaglar, M. (2016). Head of Medical Association Criticized the Health Minister of TRNC. *Cyprus Newspaper*.

Cáceda, R., Nemeroff, C. B., & Harvey, P. D. (2014). Toward an understanding of decision making in severe mental illness. *The Journal of neuropsychiatry and clinical neurosciences*, *26*(3), 196-213.

Chafetz, J. S. (Ed.). (2006). *Handbook of the Sociology of Gender*. Springer Science & Business Media.

Clement, S., Schauman, O., Graham, T., Maggioni, F., Evans-Lacko, S., Bezborodovs, N.& Thornicroft, G. (2015). What is the impact of mental health-related stigma on help-seeking? A systematic review of quantitative and qualitative studies. *Psychological medicine*, *45*(01), 11-27.

Cornaglia, F., Crivellaro, E., & McNally, S. (2012). Mental Health and Education Decisions. London: Centre for the Economics of Education, London School of Economics.

Çam, O., & Bilge, A. (2013). Türkiye'de ruhsal hastalığa/hastaya yönelik inanç, tutum ve damgalama süreci: sistematik derleme. *Psikiyatri Hemşireliği Dergisi*, *4*(2), 91-101.

Davis, L. J. (Ed.). (2006). *The disability studies reader*. Taylor & Francis Disability Rights Commission. (2006). *Equal Treatment: Closing the Gap: Information for Practitioners*. Disability Rights Commission.

Dean, K. E., Long, A. C., Matthews, R. A., & Buckner, J. D. (2017). Willingness to Seek Treatment among Black Students with Anxiety or Depression: The Synergistic Effect of Sociocultural Factors with Symptom Severity and Intolerance of Uncertainty. *Behaviour Therapy*.

Couture, S., & Penn, D. (2003). Interpersonal contact and the stigma of mental illness: A review of the literature. *Journal of mental health*, *12*(3), 291-305.

Eisenberg, D., Golberstein, E., & Hunt, J. B. (2009). Mental health and academic success in college. *The BE Journal of Economic Analysis & Policy*, *9*(1).

Eatough, V., & Smith, J. A. (2017). Interpretative phenomenological analysis. *The SAGE Handbook of Qualitative Research in Psychology*, 193.

Economou, M., Richardson, C., Gramandani, C., Stalikas, A., & Stefanis, C. (2009). Knowledge about schizophrenia and attitudes towards people with schizophrenia in Greece. *International Journal of Social Psychiatry*, *55*(4), 361-371.

Edwards, J. M., & Endler, N. S. (1989). Appraisal of stressful situations. *Personality and Individual Differences*, *10*(1), 7-10.

Ehrenreich, J. H. (2003). Understanding PTSD: forgetting "trauma". *Analyses of Social Issues and Public Policy*, *3*(1), 15-28.

Eisenberg, D., Golberstein, E., & Hunt, J. B. (2009). Mental health and academic success in college. *The BE Journal of Economic Analysis & Policy*, *9*(1).

Eker, D. (1989). Attitudes toward mental illness: Recognition, desired social distance, expected burden and negative influence on mental health among Turkish freshmen. Social Psychiatry and Psychiatric Epidemiology, 24(3), 146-150.

Elkington, K. S., Hackler, D., McKinnon, K., Borges, C., Wright, E. R., & Wainberg, M. L. (2011). Perceived mental illness stigma among youth in psychiatric outpatient treatment. *Journal of Adolescent Research*, 0743558411409931.

El-Badri, S., & Mellsop, G. (2007). Stigma and quality of life as experienced by people with mental illness. *Australasian Psychiatry*, *15*(3), 195-200.

Erikson, K. T. (1976). *Everything in its path*. Simon and Schuster.

Escobar, J. I., & Debbarma, S. (2015). Global Aspects of Chronic, Severe Mental Disorders: Realities and Opportunities for Education and Research.*FOCUS*.

European Federation of Psychologist Associations (2007), EuroPsy (2007).

Evans, D. L., Charney, D. S., Lewis, L., Golden, R. N., Gorman, J. M., Krishnan, K. R. R., ... & Delong, M. R. (2005). Mood disorders in the medically ill: scientific review and recommendations. *Biological psychiatry*, *58*(3), 175-189.

Evans-Lacko, S., Gronholm, P. C., Hankir, A., Pingani, L., & Corrigan, P. (2016). Practical strategies to fight stigma in mental health. *Psychiatry in Practice: Education, Experience, and Expertise*, 237.

Evans-Lacko, S., Henderson, C., & Thornicroft, G. (2013). Public knowledge, attitudes and behaviour regarding people with mental illness in England 2009-2012. *The British Journal of Psychiatry*, *202*(s55), s51-s57.

Fabrega Jr, H. (1991). Psychiatric stigma in non-Western societies. *Comprehensive psychiatry*, *32*(6), 534-551.

Falvo, D. (2013). *Medical and psychosocial aspects of chronic illness and disability*. Jones & Bartlett Publishers.

Fallowfield, L., Ratcliffe, D., Jenkins, V., & Saul, J. (2001). Psychiatric morbidity and its recognition by doctors in patients with cancer. *British journal of cancer*, *84*(8), 1011.

Famini, G. R., Penski, C. A., & Wilson, L. (1992). Using theoretical descriptors in quantitative structure activity relationships: some physicochemical properties. *Journal of physical organic chemistry*, *5*(7), 395-408.

Farzanfar, R. (2005). Using Qualitative Research Methods to Evaluate Automated Health Promotion/Disease Prevention Technologies: A Procedures‟ Manual. *Boston University. Robert Wood Johnson Foundation*.

Flick, U. (2002). Qualitative research-state of the art. *Social science information*, *41*(1), 5-24.

Fominaya, A. W., Corrigan, P. W., & Rüsch, N. (2016). The effects of pity on self-and other-perceptions of mental illness. *Psychiatry research*, *241*, 159-164.

Fox, C., Buchanan-Barrow, E., & Barrett, M. (2010). Children's conceptions of mental illness: A naïve theory approach. *British Journal of Developmental Psychology*, *28*(3), 603-625.

Framo, J. L. (1981). The integration of marital therapy with sessions with family of origin. *DOCUMENT RESUME*, 109.

François, C. (2016). The economic burden of schizophrenia in the United States in 2013. *The Journal of clinical psychiatry*, *77*(6), 764-771.

Frith, C. D. (2015). *The Cognitive Neuropsychology of Schizophrenia (Classic Edition)*. Psychology Press.

Funk, M. (2016). Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level.

Furnham, A., & Bower, P. (1992). A comparison of academic and lay theories of schizophrenia. *The British Journal of Psychiatry*, *161*(2), 201-210.

Gaebel, W., Baumann, A., Witte, A. M., & Zaeske, H. (2002). Public attitudes towards people with mental illness in six German cities. *European archives of psychiatry and clinical neuroscience*, *252*(6), 278-287.

Gaertner, S. L., Dovidio, J. F., Banker, B. S., Houlette, M., Johnson, K. M., & McGlynn, E. A. (2000). Reducing intergroup conflict: From superordinate goals to decategorization, recategorization, and mutual differentiation. *Group Dynamics: Theory, Research, and Practice*, *4*(1), 98.

Gazmararian, J. Baker, D. Parker, R. & Blazer D. G. (2000). A multivariate analysis of factors associated with depression: Evaluating the role of health literacy as a potential contributor. *Archives of Internal Medicine*. 160: 3307-3314.

Georg Hsu, L. K., Wan, Y. M., Chang, H., Summergrad, P., Tsang, B. Y., & Chen, H. (2008). Stigma of depression is more severe in Chinese Americans than Caucasian Americans. *Psychiatry*, *71*(3), 210-218.

Georgiades, S. (2009). Mental health in Cyprus: An exploratory investigation. *International Journal of Mental Health*, *38*(2), 3-20.

Girma, E., Tesfaye, M., Froeschl, G., Möller-Leimkühler, A. M., Müller, N., & Dehning, S. (2013). Public Stigma against People with Mental Illness in the Gilgel Gibe Field Research Center (GGFRC) in Southwest Ethiopia. *PloS one*, *8*(12), e82116.

Gioia, D. A., Corley, K. G., & Hamilton, A. L. (2013). Seeking qualitative rigor in inductive research notes on the Gioia methodology. *Organizational Research Methods*, *16*(1), 15-31.

Glaser, B. G. (1978). *Theoretical sensitivity: Advances in the methodology of grounded theory*. Sociology Pr.

Goffman, E. (1963). *Behaviour in public places: Notes on the social organization of gatherings* (p. 248). New York: Free Press.

Goffman, E. (1961). Asylums: essays on the soocial situatioon of mental patients and other inmates.

Goffman, E. (1963). Stigma: Notes on a spoiled identity. *Jenkins, JH & Carpenter*.

Goldbach, J. T., Amaro, H., Vega, W., & Walter, M. D. (2015). The Grand Challenge of Promoting Equality by Addressing Social Stigma.

Goldman, H. H., & Grob, G. N. (2006). Defining 'mental illness' in mental health policy. *Health affairs*, *25*(3), 737-749.

Gopalkrishnan, N., & Babacan, H. (2015). Cultural diversity and mental health. *Australasian Psychiatry*, *23*(6_suppl), 6-8.

Gorard, S., & Taylor, C. (2004). *Combining methods in educational and social research*. McGraw-Hill Education (UK).

Gorodnichenko, Y., & Roland, G. (2016). Culture, institutions and the wealth of nations. *Review of Economics and Statistics*, (0).

Grausgruber, A., Meise, U., Katschnig, H., Schöny, W., & Fleischhacker, W. W. (2007). Patterns of social distance towards people suffering from schizophrenia in Austria: a comparison between the general public, relatives and mental health staff. *Acta Psychiatrica Scandinavica*, *115*(4), 310-319.

Gräsner, J. T., Meybohm, P., Lefering, R., Wnent, J., Bahr, J., Messelken, M., & Fischer, M. (2011). ROSC after cardiac arrest—the RACA score to predict outcome after out-of-hospital cardiac arrest. *European heart journal*, ehr107.

Greene, J. C., & Caracelli, V. J. (2003). Making paradigmatic sense of mixed methods practice. *Handbook of mixed methods in social and behavioural research*, 91-110.

Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989). Toward a conceptual framework for mixed-method evaluation designs. *Educational evaluation and policy analysis*, *11*(3), 255-274.

Griffiths, K. M., & Christensen, H. (2006). Review of randomised controlled trials of Internet interventions for mental disorders and related conditions. *Clinical Psychologist*, *10*(1), 16-29.

Griffith, E. E., & Baker, F. M. (1993). Psychiatric care of African Americans. *Culture, ethnicity, and mental illness*, 147-173.

Guba, E. G. (Ed.). (1990). *The paradigm dialog*. Sage Publications.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of qualitative research*, *2*(163-194).

Gureje, O., Lasebikan, V. O., Ephraim-Oluwanuga, O., Olley, B. O., & Kola, L. (2005). Community study of knowledge of and attitude to mental illness in Nigeria. *The British Journal of Psychiatry*, *186*(5), 436-441.

Hajisoteriou, C. (2010). Europeanising intercultural education: Politics and policy making in Cyprus. *European Educational Research Journal*, *9*(4), 471-483.

Hall, P. A. (2013). Brother, can you paradigm?. *Governance*, *26*(2), 189-192.

Hall, P., Brockington, I. F., Levings, J., & Murphy, C. (1993). A comparison of responses to the mentally ill in two communities. *The British Journal of Psychiatry*, *162*(1), 99-108.

Halter, M. J. (2008). Perceived characteristics of psychiatric nurses: Stigma by association. *Archives of psychiatric nursing*, *22*(1), 20-26.

Hansson, L., Jormfeldt, H., Svedberg, P., & Svensson, B. (2013). Mental health professionals' attitudes towards people with mental illness: Do they differ from attitudes held by people with mental illness?. *International Journal of Social Psychiatry*, *59*(1), 48-54.

Hamid, P. D., Simmonds, J. G., & Bowles, T. V. (2009). Asian Australian acculturation and attitudes toward seeking professional psychological help. *Australian Journal of Psychology*, *61*(2), 69-76.

Hampton, N. Z., & Sharp, S. E. (2014). Shame-Focused Attitudes Toward Mental Health Problems The Role of Gender and Culture. *Rehabilitation Counseling Bulletin*, *57*(3), 170-181.

Harding, C. M., & Zahniser, J. H. (1994). Empirical correction of seven myths about schizophrenia with implications for treatment. *Acta Psychiatrica Scandinavica*, *90*(s384), 140-146.

Hannigan, B. (1999). Mental health care in the community: An analysis of contemporary public attitudes towards, and public representations of, mental illness. *Journal of Mental Health*, *8*(5), 431-440.

Hanson, B. (2008). Wither qualitative/quantitative? Grounds for methodological convergence. Quality & Quantity,42, 97-111.

Hanson W, Creswell J, Clark V, Petska K and Creswell J (2005) Mixed methods research designs in Counselling Psychology, *Journal of Counselling Psychology* 52(2): 224-235.

Hansson, L., Stjernswärd, S., & Svensson, B. (2016). Changes in attitudes, intended behaviour, and mental health literacy in the Swedish population 2009–2014: an evaluation of a national antistigma programme. *Acta Psychiatrica Scandinavica*, *134*(S446), 71-79.

Harney, L., McCurry, J., Scott, J., & Wills, J. (2016). Developing 'process pragmatism'to underpin engaged research in human geography. *Progress in Human Geography*, 0309132515623367.

Harré, J. R. N. (2001). The role of biological and genetic causal beliefs in the stigmatisation of'mental patients'. *Journal of mental health*, *10*(2), 223-235.

Hart, T. E. (2016). *How Can Young People, Aged 14-16 Years with Mental Health Problems, Be Better Supported in Mainstream Education?* (Doctoral dissertation, Department of Neuroscience, Psychology and Behaviour).

Hartsough, D. M., & Myers, D. G. (1985). Disaster work and mental health: Prevention and control of stress among workers.

Harvey, J. A., & Robinson, J. D. (2003). Eating disorders in men: Current considerations. *Journal of Clinical Psychology in Medical Settings*, *10*(4), 297-30.

Hatay, M. (2007). Is the Turkish Cypriot population shrinking. *An Overview of the Ethno-Demography of Cyprus in the Light of the Preliminary Results of the 2006 Turkish-Cypriot Census*, (2).

Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a fundamental cause of population health inequalities. *American journal of public health*, *103*(5), 813-821.

Health D: Attitudes to Mental Illness 2003 Report. 2003, London, Department of Health

Heatherton, T. F. (Ed.). (2003). *The social psychology of stigma*. Guilford Press.

Heider, J. The psychology of interpersonal relations. New York: Wiley, 1958.

Henderson C, Evans-Lacko S, Thornicroft G. (2013). Mental Illness Stigma, Help Seeking, and Public Health Programs. *American Journal of Public Health.*

Henkel, K. E., Dovidio, J. F., & Gaertner, S. L. (2006). Institutional discrimination, individual racism, and Hurricane Katrina. *Analyses of social issues and public policy*, *6*(1), 99-124.

Herek, G. M. (2007). Confronting sexual stigma and prejudice: Theory and practice. *Journal of Social Issues*, *63*(4), 905-925.

Herek, G. M. (2015). the soCial psyChology of sexual prejudiCe. *Handbook of prejudice, stereotyping, and discrimination,* 355. Chicago.

Herek, G. M., Capitanio, J. P., & Widaman, K. F. (2003). Stigma, social risk, and health policy: public attitudes toward HIV surveillance policies and the social construction of illness. *Health Psychology*, *22*(5), 533.

Herek, G. M., Gillis, J. R., & Cogan, J. C. (2015). Internalized stigma among sexual minority adults: Insights from a social psychological perspective.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of traumatic stress*, *5*(3), 377-391.

Herman, J. L., & van der Kolk, B. A. (1987). Traumatic antecedents of borderline personality disorder. *Psychological trauma*, 111-126.

Highet, N.J., Hickie, I.B. & Davenport, T.A. (2002). Monitoring awareness of and attitudes to depression in Australia. *Medical Journal of Australia*. 176(10): S63- S68.

Hilton, J. L., & von Hippel, W. (1996). Stereotypes. *Annual Review of Psychology, 47,* 237–271.

Hinshaw, S. P., & Cicchetti, D. (2000). Stigma and mental disorder: Conceptions of illness, public attitudes, personal disclosure, and social policy. *Development and psychopathology*, *12*(04), 555-598.

Hinshaw, S. P., & Stier, A. (2008). Stigma as related to mental disorders. *Annu. Rev. Clin. Psychol.*, *4*, 367-393.

Hixon, A. L. (2004). Functional health literacy: Improving health outcomes. American Academy of Family Physicians, 69, 2077–2078.

Ho, A. H., Potash, J. S., Fong, T. C., Ho, V. F., Chen, E. Y., Lau, R. H., & Ho, R. T. (2015). Psychometric properties of a Chinese version of the Stigma Scale: examining the complex experience of stigma and its relationship with self-esteem and depression among people living with mental illness in Hong Kong. *Comprehensive psychiatry*, *56*, 198-205.

Hoeger, W., & Hoeger, S. (2016). *Lifetime physical fitness and wellness: A personalized program*. Cengage Learning.

Hoffner, C. A., Fujioka, Y., Cohen, E. L., & Atwell Seate, A. (2017). Perceived media influence, mental illness, and responses to news coverage of a mass shooting. *Psychology of Popular Media Culture*, *6*(2), 159.

Holley, L. C., Stromwall, L. K., & Bashor, K. E. (2012). Reconceptualizing stigma: Toward a critical anti-oppression paradigm. *Stigma Research and Action*, *2*(2).

Hood, S., Golembiewski, E., Benbow, K., Sow, H., & Sanders Thompson, V. (2017). Who Can I Turn To? Emotional Support Availability in African American Social Networks. *Social Sciences*, *6*(3), 104.

Horwitz, A. V., & Scheid, T. L. (Eds.). (1999). *A handbook for the study of mental health: Social contexts, theories, and systems*. Cambridge University Press.

Howe, K. R. (1988). Against the quantitative-qualitative incompatibility thesis or dogmas die hard. *Educational researcher*, *17*(8), 10-16.

Hsiao, F. H., Klimidis, S., Minas, H., & Tan, E. S. (2006). Cultural attribution of mental health suffering in Chinese societies: the views of Chinese patients with mental illness and their caregivers. *Journal of clinical nursing*, *15*(8), 998-1006.

Hsin Yang, L., & Pearson, V. J. (2002). Understanding families in their own context: Schizophrenia and structural family therapy in Beijing. *Journal of Family Therapy*, *24*(3), 233-257.

Ingamells, S., Goodwin, A.M. & John, C. (1996). The influence of psychiatric hospital and community residence labels on social rejection of the mentally ill. British Journal of Clinical Psychology, 35, 359 – 367.

Jahnke, S., Philipp, K., & Hoyer, J. (2015). Stigmatizing attitudes towards people with pedophilia and their malleability among psychotherapists in training. *Child abuse & neglect*, *40*, 93-102.

Jetten, J., & Hornsey, M. J. (2014). Deviance and dissent in groups. *Annual review of psychology*, *65*, 461-485.

Joachim, G. L., & Acorn, S. (2016). Living with chronic illness: The interface of stigma and normalization. *Canadian Journal of Nursing Research Archive*, *32*(3).

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of mixed methods research*, *1*(2), 112-133.

Johnstone, M. J. (2001). Stigma, social justice and the rights of the mentally ill: Challenging the status quo. *Australian and New Zealand Journal of Mental Health Nursing*, *10*(4), 200-209.

Jonas, B. S., Frank, P., & Ingram, D. D. (1997). Are symptoms of anxiety and depression risk factors for hypertension. *Arch Fam Med*, *6*(1), 43-49.

Jones, E., Farina, A., Hastorf, A., Marcus, H., Miller, D., & Scott, R. (1984). Social Stigma: The Psychology of Marked Relationships. New York, NY: Freeman & Company.

Jorm, A.F., Korten, A.E. , Jacomb, P.A., Christensen, H., Rodgers, B. & Pollitt, P. (1997a). "Mental health literacy": A survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. *Medical Journal of Australia*. 166: 182-186.

Jorm, A. F. (2000). Mental health literacy Public knowledge and beliefs about mental disorders. *The British Journal of Psychiatry*, *177*(5), 396-401.

Jorm, A.F, Christenen, H., & Griffiths, K. (2006b) The public's ability to recognize mental disorders and their beliefs about treatment: changes in Australia over eight years. *Australia and New Zealand Journal of Psychiatry.* 40: 36-41.

Jorm, A. F., & Reavley, N. J. (2012). Changes in psychological distress in Australian adults between 1995 and 2011. *Australian and New Zealand Journal of Psychiatry*, *46*(4), 352-356.

Jootun, D., McGhee, G., & Marland, G. R. (2009). Reflexivity: promoting rigour in qualitative research. *Nursing Standard*, *23*(23), 42-46.

Jugul K, Mukherjee R, Parashar M, Jiloha RC, Ingle GK. (2007) Beliefs and attitudes towards mental health among medical professionals in Delhi. *Indian J Community Med*;32:198-200.

Jost, J. T., & Banaji, M. R. (1994). The role of stereotyping in system justification and the production of false consciousness. *British journal of social psychology*, *33*(1), 1-27.

Kalkan, M., & Odacı, H. (2005). Cinsiyet ve cinsiyet rolünün psikolojik yardım almaya ilişkin tutumlarla ilişkisi. Türk Psikolojik Danışma ve Rehberlik Dergisi, 23(3), 57-62

Knaak, S., Modgill, G., & Patten, S. B. (2014). Key ingredients of anti-stigma programs for health care providers: a data synthesis of evaluative studies. *The Canadian Journal of Psychiatry*, *59*(1_suppl), 19-26.

Kappeler, F., & Robinson, S. (2003). Defining Mental Illness: Collectivist versus Individualist Approaches. *Retrieved November*, *30*, 2007.

Kapungwe, A., Cooper, S., Mwanza, J., Mwape, L., Sikwese, A., Kakuma, R., ... & Flisher, A. J. (2010). Mental illness-stigma and discrimination in Zambia. *African Journal of Psychiatry*, *13*(3).

Karyana, M., Devine, A., Kenangalem, E., Burdarm, L., Poespoprodjo, J. R., Vemuri, R., ... & Yeung, S. (2016). Treatment-seeking behaviour and associated costs for malaria in Papua, Indonesia. *Malaria journal*, *15*(1), 536.

Ke, S., Lai, J., Sun, T., Yang, M. M., Wang, J. C. C., & Austin, J. (2015). Healthy young minds: the effects of a 1-hour classroom workshop on mental illness stigma in high school

students. *Community mental health journal*, *51*(3), 329-337.

Kedir, A., Kyrizi, A., & Martinez-Mora, F. (2012). Signalling and Productivity Effects of Overeducation: Is It Really a Waste of Resources?

Keklik, İ. (2009). Attitudes toward Seeking Professional Psychological Help: A Comparative Study of Turkish and American Graduate Students. *Eurasian Journal of Educational Research (EJER)*, (37).

Kellerman, N. (2007). Ha'avara shel traumat hasho'ah [Transmission of the Holocaust trauma]. *Yaldut betzel hasho'ah: Yeladim nitzolim ve'dor sheni*, 286-303.

Kessler, R. C., Berglund, P. A., Bruce, M. L., Koch, J. R., Laska, E. M., Leaf, P. J., ... & Wang, P. S. (2001). The prevalence and correlates of untreated serious mental illness. *Health services research*, *36*(6 Pt 1), 987.

Kidd, S., Kenny, A., & McKinstry, C. (2015). The meaning of recovery in a regional mental health service: an action research study. *Journal of advanced nursing*, *71*(1), 181-192.

Killaspy, H., White, S., Lalvani, N., Berg, R., Thachil, A., Kallumpuram, S., ... & Mezey, G. (2014). The impact of psychosis on social inclusion and associated factors. *International Journal of Social Psychiatry*, *60*(2), 148-154.

Kim, K. H. (2013). IPA analysis according to the attributes of the franchise coffee shop selection of college students in Busan. *Journal of the Korean Society of Food Culture*, *28*(2), 195-203.

Kim, D., Kim, C. H., Moon, J. I., Chung, Y. G., Chang, M. Y., Han, B. S., & Kim, K. S. (2009). Generation of human induced pluripotent stem cells by direct delivery of reprogramming proteins. *Cell stem cell*, *4*(6), 472.

Kim, B. S., Atkinson, D. R., & Yang, P. H. (1999). The Asian Values Scale: Development, factor analysis, validation, and reliability. *Journal of counseling Psychology*, *46*(3), 342.

Kirmayer, L. J. (2001). Cultural variations in the clinical presentation of depression and anxiety: implications for diagnosis and treatment. *Journal of Clinical Psychiatry*, *62*, 22-30.

Kishore, J., Gupta, A., Jiloha, R. C., & Bantman, P. (2011). Myths, beliefs and perceptions about mental disorders and health-seeking behaviour in Delhi, India. *Indian journal of Psychiatry*, *53*(4), 324.

Klin, A., & Lemish, D. (2008). Mental disorders stigma in the media: Review of studies on production, content, and influences. *Journal of health communication*, *13*(5), 434-449.

Kleinman, A. (1988). *The illness narratives: Suffering, healing, and the human condition*. Basic books.

Knafo, A., & Schwartz, S. H. (2001). Value socialization in families of Israeli-born and Soviet-born adolescents in Israel. *Journal of Cross-Cultural Psychology*, *32*(2), 213-228.

Knapp, M., & Byford, S. (2006). Economic evaluation and mental health.

Knopf, D., Park, M. J., & Mulye, T. P. (2008). The mental health of adolescents: A national profile, 2008. *San Francisco, CA: National Adolescent Health Information Center*.

Kolind, T., Søgaard, T. F., Hunt, G., & Thylstrup, B. (2017). Transitional narratives of identity among ethnic minority youth gangs in Denmark: from collectivism to individualism. *Journal of Scandinavian Studies in Criminology and Crime Prevention*, *18*(1), 3-19.

Komiya, N., Good, G. E., & Sherrod, N. B. (2000). Emotional openness as a predictor of college students' attitudes toward seeking psychological help. *Journal of counseling psychology*, *47*(1), 138.

Kosyluk, K. A., Al-Khouja, M., Bink, A., Buchholz, B., Ellefson, S., Fokuo, K., & Powell, K. (2016). Challenging the stigma of mental illness among college students. *Journal of Adolescent Health*, *59*(3), 325-331.

Kramer, E.J., Guarnaccia, P., Resendez, C., Lu, F.G., Barreras, B., & Brainin-Rodriguez, J. (2005). No soy loco/I'm not crazy: Understanding the stigma of mental illness in Latinos.

Krauss, S. E. (2005). Research paradigms and meaning making: A primer. *The qualitative report*, *10*(4), 758-770. Chicago.

Kroeber, A. L., and Kluckhohn, C. (1952). Culture: A critical review of concepts and definitions. *Papers. Peabody Museum of Archaeology & Ethnology, Harvard University*.

Krugman, S. (1987). Trauma in the family: Perspectives on the intergenerational transmission of violence. *Psychological trauma*, 127-151.

Krupchanka, D., Kruk, N., Sartorius, N., Davey, S., Winkler, P., & Murray, J. (2017). Experience of stigma in the public life of relatives of people diagnosed with schizophrenia in the Republic of Belarus. *Social psychiatry and psychiatric epidemiology*, *52*(4), 493-501.

Krystal, H. (1978). Trauma and affects. *The psychoanalytic study of the child*.

Kuale, S. (1996) *Interviews: an Introduction to Qualitative Research Interviewing*. California, USA: Sage.

Kurzban, R., & Leary, M. R. (2001). Evolutionary origins of stigmatization: the functions of social exclusion. *Psychological bulletin*, *127*(2), 187.

Kuhn, T. (1962). 1970. *The structure of scientific revolutions*, 31-65.

Kuhn, T. (1970). S. 1962. *The structure of scientific revolutions*.

Kurihara, T., Kato, M., Sakamoto, S., Reverger, R., & Kitamura, T. (2000). Public attitudes towards the mentally ill: A cross-cultural study between Bali and Tokyo. *Psychiatry and Clinical Neurosciences*, *54*(5), 547-552.

Lam, C. S., Tsang, H. W., Corrigan, P. W., Lee, Y. T., Angell, B., Shi, K., & Larson, J. E. (2010). Chinese lay theory and mental illness stigma: Implications for research and practices. *Journal of Rehabilitation*, *76*(1), 35.

Latalova, K., Kamaradova, D., & Prasko, J. (2014). Perspectives on perceived stigma and self-stigma in adult male patients with depression. *Neuropsychiatric disease and treatment*, *10*, 1399.

Lauber, C., Anthony, M., Ajdacic-Gross, V., & Rössler, W. (2004). What about psychiatrists' attitude to mentally ill people?. *European Psychiatry*, *19*(7), 423-427.

Lauber, C., Nordt, C., Falcato, L., & Rössler, W. (2004). Factors influencing social distance toward people with mental illness. *Community mental health journal*, *40*(3), 265-274.

Lauber, C., & Rössler, W. (2007). Stigma towards people with mental illness in developing countries in Asia. *International review of psychiatry*, *19*(2), 157-178.

Lee, J. (2015, January). Understanding the Relationship Between Personal Trauma History and Secondary Traumatic Stress: The Mediating Role of the Current Impact of Personal Trauma History. In *Society for Social Work and Research 19th Annual Conference: The Social and Behavioural Importance of Increased Longevity*. Sswr.

Leiderman, E., Vazquez, G., Berizzo, C., Bonifacio, A., Bruscoli, N., Capria, J. I., Milev, R. (2011). Public knowledge, beliefs and attitudes towards patients with schizophrenia: Buenos Aires. *Social Psychiatry and Psychiatric Epidemiology*, 46(4), 281-290.

Lesniak, L. P. (1993). Penetrating the conspiracy of silence: Identifying the family at risk for incest. *Family & Community Health*, *16*(2), 66-76.

Leucht, S., Burkard, T., Henderson, J., Maj, M., & Sartorius, N. (2007). Physical illness and schizophrenia: a review of the literature. *Acta Psychiatrica Scandinavica*, *116*(5), 317-333.

Lev-Wiesel, R., Nuttman-Shwartz, O., & Sternberg, R. (2006). Peer rejection during adolescence: Psychological long-term effects—A brief report. *Journal of Loss and Trauma*, *11*(2), 131-142.

Lev–Wiesel, R. (2007). Intergenerational transmission of trauma across three generations: A preliminary study. *Qualitative Social Work*, *6*(1), 75-94.

Lien, Y. J., Chang, H. A., Kao, Y. C., Tzeng, N. S., Lu, C. W., & Loh, C. H. (2016). Insight, self-stigma and psychosocial outcomes in Schizophrenia: a structural equation modelling approach. *Epidemiology and psychiatric sciences*, 1-10.

Lim, K. L., Jacobs, P., Ohinmaa, A., Schopflocher, D., & Dewa, C. S. (2008). A new population-based measure of the economic burden of mental illness in Canada. *Chronic Dis Can*, *28*(3), 92-98.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual review of Sociology*, 363-385.

Link, B.G., Phelan, J.C., Bresnahan, M., Stueve, A. & Pescosolido, B.A.(September, 1999). Public conceptions of mental illness: Labels, causes, dangerousness and social distance. American Journal of Public Health. 89(9): 1328-1333.

Link, B. G., Yang, L. H., Phelan, J. C., & Collins, P. Y. (2004). Measuring mental illness stigma. *Schizophrenia Bulletin*, *30*(3), 511-541.

Link, B. G., Phelan, J. C., & Sullivan, G. (2017). Mental and physical health consequences of the stigma associated with mental illnesses. In *The Oxford Handbook of Stigma, Discrimination, and Health*.

Link, B. G., Wells, J., Phelan, J. C., & Yang, L. (2015). Understanding the importance of "symbolic interaction stigma": How expectations about the reactions of others adds to the burden of mental illness stigma. *Psychiatric rehabilitation journal*, *38*(2), 117.

Littlewood, R. 1998. Cultural variation in the stigmatisation of mental illness. Lancet, 352, 1056–1057.

Liu, H., Feng, T., Ha, T., Liu, H., Cai, Y., Liu, X., & Li, J. (2011). Chinese culture, homosexuality

stigma, social support and condom use: a path analytic model. *Stigma research and action*, *1*(1), 27.

Livingston, J. D., & Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social science & medicine*, *71*(12), 2150-2161.

Livingston, G., Leavey, G., Kitchen, G., Manela, M., Sembhi, S., & Katona, C. (2002). Accessibility of health and social services to immigrant elders: the Islington Study. *The British Journal of Psychiatry*, *180*(4), 369-373.

Livingston, J. D., Milne, T., Fang, M. L., & Amari, E. (2012). The effectiveness of interventions for reducing stigma related to substance use disorders: a systematic review. *Addiction*, *107*(1), 39-50. Chicago.

Livingstone, J. D., Tugwell, A., Korf-Uzan, K., Cianfrone, M., & Coniglio, C. (2013). Evaluation of a campaign to improve awareness and attitudes of young people towards mental health issues. *Social psychiatry and psychiatric epidemiology*, *48*(6), 965-973.

Leff, J., & Warner, R. (2006). *Social inclusion of people with mental illness*. Cambridge University Press.

Loizos, P. (1981). *The heart grown bitter: A chronicle of Cypriot war refugees*. CUP Archive.

Longdon, E., & Read, J. (2017). 'People with Problems, Not Patients with Illnesses': Using Psychosocial Frameworks to Reduce the Stigma of Psychosis. *The Israel journal of psychiatry and related sciences*, *54*(1), 24-28.

Macabasco-O'Connell, A., DeWalt, D. A., Broucksou, K. A., Hawk, V., Baker, D. W., Schillinger, D., & Weinberger, M. (2011). Relationship between literacy, knowledge, self-care behaviours, and heart failure-related quality of life among patients with heart failure. *Journal of general internal medicine*, *26*(9), 979-986.

MacFarlane, K., & Korbin, J. (1983). Confronting the incest secret long after the fact: A family study of multiple victimization with strategies for intervention. *Child abuse & neglect*, *7*(2), 225-237.

Machine, E. M., Ross, M. W., & McCurdy, S. A. (2011). Issues of expressed stigma of HIV/AIDS among professionals in Southern Sudan. *Qualitative health research*, *21*(8), 1041-1050.

Mackay, R., Bradstreet, S., McArthur, A., & Dunion, L. (2015). Dyad conversations about self-stigma in two Scottish communities. *Psychiatric rehabilitation journal*, *38*(2), 194.

Mackenzie, N., & Knipe, S. (2006). Research dilemmas: Paradigms, methods and methodology. *Issues in educational research*, *16*(2), 193-205.

Madianos MG, Economou M, Hatjiandreou M, Papageorgiou A, Rogakou E (1999) Changes in public attitudes toward mental ill- ness in the Athens area (1979/1980–1994). Acta Psychiatr Scand 99 (1): 73–78

Madianos, M. G., Madianou, D., Vlachonikolis, J., & Stefanis, C. N. (1987). Attitudes towards mental illness in the Athens area: implications for community mental health intervention. *Acta Psychiatrica Scandinavica*, *75*(2), 158-165.

Major, B., & O'Brien, L. T. (2005). The social psychology of stigma. *Annu. Rev. Psychol.*, *56*, 393-421.

Mak, W. W., & Cheung, R. Y. (2008). Affiliate stigma among caregivers of people with intellectual disability or mental illness. *Journal of Applied Research in Intellectual Disabilities*, *21*(6), 532-545.

Malla, A., Joober, R., & Garcia, A. (2015). "Mental illness is like any other medical illness": a critical examination of the statement and its impact on patient care and society. *Journal of psychiatry & neuroscience: JPN*, *40*(3), 147.

Mann, C.E. & Himelein, M.J. (February, 2004). Factors associated with stigmatization of persons with mental illness. Psychiatric Services. 55:185-187.

Maranzan, K. A. (2016). Interprofessional education in mental health: an opportunity to reduce mental illness stigma. *Journal of interprofessional care*, *30*(3), 370-377.

Markström, U., Gyllensten, A. L., Bejerholm, U., Björkman, T., Brunt, D., Hansson, L. & Eklund, M. (2009). Attitudes towards mental illness among health care students at Swedish universities–A follow-up study after completed clinical placement. *Nurse education today*, *29*(6), 660-665.

Markus, H. R., & Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological review*, *98*(2), 224.

Markus, H. R., & Kitayama, S. (2010). Cultures and selves: A cycle of mutual constitution. *Perspectives on Psychological Science*, *5*(4), 420-430.

Marrow, J., & Luhrmann, T. M. (2012). The zone of social abandonment in cultural geography: on the street in the United States, inside the family in India. *Culture, Medicine, and Psychiatry*, *36*(3), 493-513.

Martin, L. A., Neighbors, H. W., & Griffith, D. M. (2013). The experience of symptoms of depression in men vs women: analysis of the National Comorbidity Survey Replication. *JAMA psychiatry*, *70*(10), 1100-1106.

Martinez, A. G., Piff, P. K., Mendoza-Denton, R., & Hinshaw, S. P. (2011). The power of a label: Mental illness diagnoses, ascribed humanity, and social rejection. *Journal of social and clinical psychology*, *30*(1), 1-23.

Marušič, A. (2004). Mental health in the enlarged European Union: need for relevant public mental health action. *The British Journal of Psychiatry*, *184*(5), 450-451.

Marwaha, S., & Johnson, S. (2005). Views and experiences of employment among people with psychosis: a qualitative descriptive study. *International Journal of Social Psychiatry*, *51*(4), 302-316.

Mantovani, N., Pizzolati, M., & Edge, D. (2017). Exploring the relationship between stigma and help-seeking for mental illness in African-descended faith communities in the UK. *Health Expectations*, *20*(3), 373-384.

Maxcy, S. J. (2003). Pragmatic threads in mixed methods research in the social sciences: The search for multiple modes of inquiry and the end of the philosophy of formalism. *Handbook of mixed methods in social and behavioural research*, 51-89.

Matthews, G., & Stolarski, M. (2015). Emotional processes in development and dynamics of individual time perspective. In *Time Perspective Theory; Review, Research and Application* (pp. 269-286). Springer International Publishing.

McAleenan, K. (2013). *Perceptions of Mental Illness and Mental Health Policy* (Doctoral dissertation, Connecticut College).

McArthur, A. & Dunion, D. (2007) *A Fairer Future. Building Understanding. Moving forward Together*. ‘see me’ .

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of traumatic stress*, *3*(1), 131-149.

McCauley, C. R., Jussim, L. J., & Lee, Y. T. (1995). *Stereotype accuracy: Toward appreciating group differences*. American Psychological Association.

McDaid, D., Sassi, F., & Merkur, S. (2015). Supporting effective and efficient policies: the role of economic analysis. *Promoting Health, Preventing Disease The Economic Case: The Economic Case*, 19.

McGorry, P. D., Tanti, C., Stokes, R., Hickie, I. B., Carnell, K., Littlefield, L. K., & Moran, J. (2007). headspace: Australia's National Youth Mental Health Foundation-where young minds come first. *Medical Journal of Australia*, *187*(7), S68.

McKinley, P. K., & Trefftz, C. (1993). Multisim: A simulation tool for the study of large-scale multiprocessors. In *In Proceedings of the 1993 International Workshop on Modeling, Analysis, and Simulation of Computer and Telecommunications Networks (MASCOTS)*.

Mehraby, N. (2009). Possessed or crazy? Mental illness across cultures. *Psychotherapy in Australia*, *15*(2), 43.

Mehta, N., Clement, S., Marcus, E., Stona, A. C., Bezborodovs, N., Evans-Lacko, S., & Koschorke, M. (2015). Evidence for effective interventions to reduce mental health-related stigma and discrimination in the medium and long term: systematic review. *The British Journal of Psychiatry*, *207*(5), 377-384.

Mellor, David, Carne, Lucy, Shen, Yu-Chun*, McCabe, Marita and Wang, Liwei* (2013) Stigma toward mental illness : a cross-cultural comparison of Taiwanese, Chinese immigrants to Australia and Anglo-Australians, *Journal of cross-cultural psychology*, vol. 44, no. 3, pp. 352-364, Sage Publications, Thousand Oaks, Calif.

Mental Health Policy, Republic of Cyprus. (1931).

Mental Health Literacy: A Review of the Literature Bourget Management Consulting for the Canadian Alliance on Mental Illness and Mental Health November 2004; Updated May 2007.

Mesquita, B. (2001). Emotions in collectivist and individualist contexts. *Journal of personality and social psychology*, *80*(1), 68.

Michalak, E. E., Livingston, J. D., Maxwell, V., Hole, R., Hawke, L. D., & Parikh, S. V. (2014). Using theatre to address mental illness stigma: a knowledge translation study in bipolar disorder. *International journal of bipolar disorders*, *2*(1), 1.

Miller, N., Brewer, M. B., & Edwards, K. (1985). Cooperative interaction in desegregated settings: A laboratory analogue. *Journal of Social Issues*, *41*(3), 63-79.

Mishra, S. I., Lucksted, A., Gioia, D., Barnet, B., & Baquet, C. R. (2009). Needs and preferences for receiving mental health information in an African American focus group sample. *Community Mental Health Journal*, *45*(2), 117-126.

Mohammed K, Zubair I, Isa A, Muktar A (2004) Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria. BMC International Health and Human Rights 4: 3.

Mojtabai, R. (2010). Mental illness stigma and willingness to seek mental health care in the European Union. *Social psychiatry and psychiatric epidemiology*, *45*(7), 705-712.

Mora-Rios, J., Ortega-Ortega, M., & Natera, G. (2015). Subjective Experience and Resources for Coping With Stigma in People With a Diagnosis of Schizophrenia An Intersectional Approach. *Qualitative health research*, 1049732315570118.

Moran, R. T., Abramson, N. R., & Moran, S. V. (2014). *Managing cultural differences*. Routledge.

Morgan, D. L. (1998). Practical strategies for combining qualitative and quantitative methods: Applications to health research. *Qualitative health research*, *8*(3), 362-376.

Morgan, C., Burns, T., Fitzpatrick, R., Pinfold, V., & Priebe, S. (2007). Social exclusion and mental health. *The British Journal of Psychiatry*, *191*(6), 477-483.

Morse, J. M. (2003). Principles of mixed methods and multimethod research design. *Handbook of mixed methods in social and behavioural research*, 189-208.

Mukherjee, R., Fialho, A., Wijetunge, A., Checinski, K., & Surgenor, T. (2002). The stigmatisation of psychiatric illness. *The Psychiatrist*, *26*(5), 178-181.

Muhamadi, L., Nsabagasani, X., Tumwesigye, M. N., Wabwire-Mangen, F., Ekström, A. M.,

Murphy, M., & Fonagy, P. (2012). Mental health problems in children and young people. *Annual Report of the Chief*.

Muhamadi, L., Nsabagasani, X., Tumwesigye, M. N., Wabwire-Mangen, F., Ekström, A. M., Peterson, S., & Pariyo, G. (2010). Inadequate pre-antiretroviral care, stock-out of

antiretroviral drugs and stigma: Policy challenges/bottlenecks to the new WHO recommendations for earlier initiation of antiretroviral therapy (CD< 350 cells/μL) in eastern Uganda. *Health policy*, *97*(2), 187-194.

Mulvany, J. (2000). Disability, impairment or illness? The relevance of the social model of disability to the study of mental disorder. *Sociology of Health & Illness*, *22*(5), 582-601.

Mutch, C. (2005). *Doing educational research: A practitioner's guide to getting started*. NZCER Press.

National Center for Health Statistics, Centers for Disease Control, & Preventi (Eds.). (2015). *Health, United States, 2013, with special feature on prescription drugs*. Government Printing Office.

Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossey, M., & Galea, A. (2012). Long-term conditions and mental health: the cost of co-morbidities.

Nee, C., & Witt, C. (2013). Public perceptions of risk in criminality: The effects of mental illness and social disadvantage. *Psychiatry research*, *209*(3), 675-683.

Neufeld, A., Harrison, M. J., Hughes, K. D., Spitzer, D., & Stewart, M. J. (2001). Participation of immigrant women family caregivers in qualitative research. *Western Journal of Nursing Research*, *23*(6), 575-591.

Newnham, E. A., Pearson, R. M., Stein, A., & Betancourt, T. S. (2015). Youth mental health after civil war: the importance of daily stressors. *The British Journal of Psychiatry*, *206*(2), 116-121.

Ngui, E. M., Khasakhala, L., Ndetei, D., & Roberts, L. W. (2010). Mental disorders, health inequalities and ethics: A global perspective. *International Review of Psychiatry*, *22*(3), 235-244.

Niglas, K. (2004). *The combined use of qualitative and quantitative methods in educational research*. Tallinna Pedagoogikaülikooli Kirjastus.

Norman, R. M., Sorrentino, R. M., Gawronski, B., Szeto, A. C., Ye, Y., & Windell, D. (2010). Attitudes and physical distance to an individual with schizophrenia: the moderating effect of self-transcendent values. *Social psychiatry and psychiatric epidemiology*, *45*(7), 751-758.

Office of the Surgeon General (US, & Center for Mental Health Services (US. (2001). Mental health: Culture, race, and ethnicity: A supplement to mental health: A report of the surgeon general. USDHHS. Mental Health: Culture, Race, and Ethnicity: A supplement to mental health: A report of the Surgeon General. Rockville: US Department of Health and Human Services, 2001.

Öncer, A. Z. (2013). The Relationship between Individualism-Collectivism and Organizations' Espoused Values. *The Business & Management Review*, *3*(3), 105.

Panayiotopoulos C, Pavlakis A, Apostolou M (2012). Improving mental health services through the measurement of attitudes and knowledge of mental health professionals and the general population in Cyprus. *Int J Ment Heal*, 41(4):29-46.

Papadakis, Y. (2005). *Echoes from the dead zone: Across the Cyprus divide*. IB Tauris.

Papadopoulos, C. (2009). *Stigma towards people with mental health problems: an individualism-collectivism cross-cultural comparison* (Doctoral dissertation, Middlesex University).

Papadopoulos, C., Foster, J., & Caldwell, K. (2013). 'Individualism-collectivism'as an explanatory device for mental illness stigma. *Community mental health journal*, *49*(3), 270-280.

Papadopoulos, C., Leavey, G., & Vincent, C. (2002). Factors influencing stigma A comparison of Greek-Cypriot and English attitudes towards mental illness in north London. *Social psychiatry and psychiatric epidemiology*, *37*(9), 430-434.

Parkar SR, Dawani VS, Apte JS. (2001)History of psychiatry in India. J Postgrad Med. 47:73–6.

Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Social science & medicine*, *57*(1), 13-24.

Patel, V., Chisholm, D., Parikh, R., Charlson, F. J., Degenhardt, L., Dua, T., & Lund, C. (2016). Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities. *The Lancet*, *387*(10028), 1672-1685.

Patel, V., & Kleinman, A. (2003). Poverty and common mental disorders in developing countries. *Bulletin of the World Health Organization*, *81*(8), 609-615.

Paterson, R. J., & Neufeld, R. W. (1987). Clear danger: situational determinants of the appraisal of threat. *Psychological bulletin*, *101*(3), 404.

Patten, S. B., Wang, J. L., Williams, J. V., & Currie, S. (2006). Descriptive epidemiology of major depression in Canada. *Canadian journal of psychiatry*, *51*(2), 84.

Patton, M. Q. (1990). *Qualitative evaluation and research methods* . SAGE Publications, inc.

Patton, M. Q. (2005). *Qualitative research*. John Wiley & Sons, Ltd.

Pavlov, I. P. (1960). *Conditional reflexes*. Dover.

Peluso, É. D. T. P., & Blay, S. L. (2009). Public stigma in relation to individuals with depression. *Journal of affective disorders*, *115*(1), 201-206.

Penn, D. L., Kommana, S., Mansfield, M., & Link, B. G. (1999). Dispelling the stigma of schizophrenia: II. The impact of information on dangerousness. *Schizophrenia Bulletin*, *25*(3), 437-446.

Perlick, D. A., Rosenheck, R. A., Clarkin, J. F., Sirey, J. A., Salahi, J., Struening, E. L., & Link, B. G. (2001). Stigma as a barrier to recovery: adverse effects of perceived stigma on social adaptation of persons diagnosed with bipolar affective disorder. *Psychiatric services*.

Pescosolido, B. A. (2013). The Public Stigma of Mental Illness What Do We Think; What Do We Know; What Can We Prove?. *Journal of Health and Social Behaviour*, *54*(1), 1-21.

Pescosolido, B. A., Martin, J. K., Lang, A., & Olafsdottir, S. (2008). Rethinking theoretical approaches to stigma: A framework integrating normative influences on stigma (FINIS). *Social science & medicine*, *67*(3), 431-440.

Peterson,S., & Pariyo, G. (2010). Inadequate pre-antiretroviral care, stock-out of antiretroviral drugs and stigma: Policy challenges/bottlenecks to the new WHO recommendations for earlier initiation of antiretroviral therapy (CD< 350 cells/μL) in eastern Uganda. *Health policy*, *97*(2), 187-194.

Phelan JC, Bromet EJ, Link BG (1998) Psychiatric illness and family stigma. Schizophr Bull 24: 115–126. doi:

Phelan, J. C., Link, B. G., Stueve, A., and Pescosolido, B. A. (2000). Public conceptions of mental illness in 1950 and 1996: What is mental illness and is it to be feared?. *Journal of Health and Social Behaviour*, 188-207.

Pickard, H. (2011). Responsibility without blame: empathy and the effective treatment of personality disorder. *Philosophy, psychiatry, & psychology: PPP*, *18*(3), 209.

Pierides, M. (1994). Mental health services in Cyprus. *The Psychiatrist*, *18*(7), 425-427.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, *20*(1), 7-14.

Pingani, L., Forghieri, M., Ferrari, S., Ben-Zeev, D., Artoni, P., Mazzi, F. and Corrigan, P. W. (2012). Stigma and discrimination toward mental illness: translation and validation of the Italian version of the attribution questionnaire-27 (AQ-27-I). *Social psychiatry and psychiatric epidemiology*, *47*(6), 993-999.

Pinfold, V., Toulmin, H., Thornicroft, G., Huxley, P., Farmer, P., & Graham, T. (2003). Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools. *The British Journal of Psychiatry*, *182*(4), 342-346.

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, M. R., & Rahman, A. (2007). No health without mental health. *The lancet*, *370*(9590), 859-877.

Pring, R. (2000). Philosophy of educational research. London: Continuum.

Poliniki, A. (2011). Attitudes of general practitioners and the general public towards severe psychiatric disorders in Cyprus. Unpublished thesis. Open University of Cyprus, Nicosia.

Porter, R. (2002). Madness: A brief history.

Power, A. K. (2015). Focus on transformation: A public health model of mental health for the 21st century. *Psychiatric Services*.

Pryor, J. B., & Bos, A. E. (2015). Stigma: Implications for Helping. *The Oxford Handbook of Prosocial Behaviour*, 433.

Psaltis, C., Cabrera, C., Lytra, E., Filippou, G., Cakal, H., & Makriyianni, C. (2014). Oral history accounts of the former inhabitants of mixed villages in Cyprus: A social representations perspective. *Oral history in Cyprus*, 34-50.

Puac-Polanco, V. D., Lopez-Soto, V. A., Kohn, R., Xie, D., Richmond, T. S., & Branas, C. C. (2015). Previous violent events and mental health outcomes in Guatemala. *American journal of public health*, *105*(4), 764-771.

Rahav, M., Struening, E. L., & Andrews, H. (1984). Opinions on mental illness in Israel. *Social Science & Medicine*, *19*(11), 1151-1158.

Rajagopalan, M., & Kuruvilla, K. (1994). MEDICAL STUDENTS'ATTITUDES TOWARDS PSYCHIATRY: EFFECT OF A TWO WEEK POSTING. *Indian journal of psychiatry*, *36*(4), 177.

Ram, M. (2015). Colonial conquests and the politics of normalization: The case of the Golan Heights and Northern Cyprus. *Political Geography*, *47*, 21-32.

Rao, D., Feinglass, J., & Corrigan, P. (2007). Racial and ethnic disparities in mental illness stigma. *The Journal of nervous and mental disease*, *195*(12), 1020-1023.

Rao, D., Kekwaletswe, T. C., Hosek, S., Martinez, J., & Rodriguez, F. (2007). Stigma and social barriers to medication adherence with urban youth living with HIV. *AIDS care*, *19*(1), 28-33.

Read, M. (2013). *Culture, health and disease: social and cultural influences on health programmes in developing countries*. Routledge.

Remer, R., & Elliott, J. E. (1988). Characteristics of secondary victims of sexual assault. *International Journal of Family Psychiatry*.

Reports of the Secretary General: Report of the Secretary General on his Mission of Good Offices in Cyprus (S/2004/437), para. 93.

Reichard, C. S., & Cook, T. D. (1979). Qualitative and quantitative methods in evaluation research.

Rickwood, D., Cavanagh, S., Curtis, L., & Sakrouge, R. (2004). Educating young people about mental health and mental illness: evaluating a school-based programme. *International Journal of Mental Health Promotion*, *6*(4), 23-32.

Ritterfield, U., & Jin, S. A. (2006). Addressing media stigma for people experiencing mental illness using an entertainment-education strategy. Journal of Health Psychology, 11, 247-267.

Robles, T. F., & Kiecolt-Glaser, J. K. (2003). The physiology of marriage: Pathways to health. *Physiology & behaviour*, *79*(3), 409-416.

Robles, T. F., Slatcher, R. B., Trombello, J. M., & McGinn, M. M. (2014). Marital quality and health: A meta-analytic review. *Psychological bulletin*, *140*(1), 140.

Rocco, T. S. R. T. S., Bliss, L. A. B. L. A., Gallagher, S. G. S., Pérez, A. P. A., & Prado, P. (2003). Taking the next step: Mixed methods taking the next step: Mixed methods research in organizational systems research in organizational systems. *Information Technology, Learning, and Performance Journal*, *21*(1), 19.

Roman, P. M., & Floyd Jr, H. H. (1981). Social acceptance of psychiatric illness and psychiatric treatment. *Social Psychiatry*, *16*(1), 21-29.

Rose, S., Brewin, C. R., Andrews, B., & Kirk, M. (1999). A randomized controlled trial of individual psychological debriefing for victims of violent crime. *Psychological Medicine*, *29*(04), 793-799.

Rose, D., Thornicroft, G., Pinfold, V., & Kassam, A. (2007). 250 labels used to stigmatise people with mental illness. *BMC Health Services Research*, *7*(1), 97.

Rosenheck, R., & Nathan, P. (1985). Secondary traumatization in children of Vietnam veterans. *Hospital & Community Psychiatry*.

Rossman, G. B., & Rallis, S. F. (2003). *Learning in the field: An introduction to qualitative research*. Sage.

Rossman, G. B., & Wilson, B. L. (1985). Numbers and words combining quantitative and qualitative methods in a single large-scale evaluation study. *Evaluation review*, *9*(5), 627-643.

Rossman, G. B., & Wilson, B. L. (1994). Numbers and words revisited: Being "shamelessly eclectic". *Quality and Quantity*, *28*(3), 315-327.

Rootman, I. & Ronson, B. (2005). Literacy and health research in Canada: Where have we been and where should we go? Canadian Journal of Public Health, 96, S62–77.

Rowland-Klein, D., & Dunlop, R. (1998). The transmission of trauma across generations: Identification with parental trauma in children of Holocaust survivors. *Australian and New Zealand Journal of Psychiatry*, *32*(3), 358-369.

Rubenking, B., & Bracken, C. C. (2015). The Dueling Influences on Stigma toward Mental Illness: Effects of Interpersonal Familiarity and Stigmatizing Mediated Portrayals of Mental Illness on Attitudes. *Studies in Media and Communication*, *3*(2), 120-128.

Rüsch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: concepts, consequences, and initiatives to reduce stigma. *European psychiatry*, *20*(8), 529-539.

Rusch N, Angermeyer MC, Corrigan PW. Mental illness stigma:SEPConcepts, consequences, and initiatives to reduce stigma. *European Psychiatry*. 2005; 20:529–539.

Sabatini, F., & Sarracino, F. (2014). Will Facebook save or destroy social capital? An empirical investigation into the effect of online interactions on trust and networks.

Sagie, S., Eliasi, Y., Livneh, I., Bart, Y., & Monovich, E. (2013). [Short-and long-term effects of cannabinoids on memory, cognition and mental illness]. *Harefuah*, *152*(12), 737-41.

Samovar, L., Porter, R., McDaniel, E., & Roy, C. (2015).*Communication between cultures*. Nelson Education.

Sainsbury, R., Irvine, A., Aston, J., Wilson, S., Williams, C., & Sinclair, A. (2008). *Mental health and employment* (Vol. 513). Corporate Document Services.

Sanchez, F., & Gaw, A. (2007). Mental health care of Filipino Americans. *Psychiatric Services*.

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in nursing science*, *8*(3), 27-37.

Sarantakos, S. (2005). Social Research. 3rd. *Hampshire: Palgrave Macmillan*.

Sarıkoç, G., & Öz, F. (2016). The effects and stigma of mental illness in Turkey. *Community mental health journal*, *52*(3), 353-360.

Sartorius, N. (2001, September). The vicious circles of stigma. In *First International Conference on Reducing Stigma and Discrimination because of Schizophrenia*.

Sartorius, N. (2002). Iatrogenic stigma of mental illness. *BMJ*, *324*(7352), 1470-1471.

Sartorius N, and Schulze H (2005) Reducing the Stigma of Mental Illness. A Report from a Global Programme of the World Psychiatric Association Cambridge, Cambridge University Press.

Savrun, B. M., Arikan, K., Uysal, O., & Cetin, G. (2007). Gender effect on attitudes towards the mentally ill: A survey of Turkish university students. *The Israel journal of psychiatry and related sciences*, *44*(1), 57.

Sayce, L. (2000). From psychiatric patient to citizen.

Scambler, G. (2009). Health-related stigma. *Sociology of health & illness*, *31*(3), 441-455.

Scharf, M., & Mayseless, O. (2011). Disorganizing experiences in second-and third-generation holocaust survivors. *Qualitative health research*, *21*(11), 1539-1553.

Scheffer, R., & Director, P. E. (2003). *Addressing stigma: Increasing public understanding of mental illness*. Centre of Addiction and Mental Health.

Schenner, M., Kohlbauer, D., & Günther, V. (2010). Communicate instead of stigmatizing-does social contact with a depressed person change attitudes of medical students towards psychiatric disorders? A study of attitudes of medical students to psychiatric patients. *Neuropsychiatrie: Klinik, Diagnostik, Therapie und Rehabilitation: Organ der Gesellschaft Osterreichischer Nervenarzte und Psychiater*, *25*(4), 199-207.

Schnittker, J. (2008). An uncertain revolution: Why the rise of a genetic model of mental illness has not increased tolerance. *Social science & medicine*, *67*(9), 1370-1381.

Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P. W., Grabe, H. J., Carta, M. G., &

Angermeyer, M. C. (2012). Evolution of public attitudes about mental illness: a systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*, *125*(6), 440-452.

Schuch, J. J., Roest, A. M., Nolen, W. A., Penninx, B. W., & de Jonge, P. (2014). Gender differences in major depressive disorder: results from the Netherlands study of depression and anxiety. *Journal of affective disorders*, *156*, 156-163.

Schulze, S. (2003). Views on the combination of quantitative and qualitative research approaches. *Progressio*, *25*(2), p-8.

Schulze, B., & Angermeyer, M. C. (2003). Subjective experiences of stigma. A focus group study of schizophrenic patients, their relatives and mental health professionals. *Social science & medicine*, *56*(2), 299-312.

Seeman, N., Tang, S., Brown, A. D., & Ing, A. (2016). World survey of mental illness stigma. *Journal of affective disorders*, *190*, 115-121.

Seipel, C., & Rieker, P. (2003). *Integrative Sozialforschung: Konzepte und Methoden der qualitativen und quantitativen empirischen Forschung*. Beltz Juventa.

Sellers, R. M., Smith, M. A., Shelton, J. N., Rowley, S. A., & Chavous, T. M. (1998). Multidimensional model of racial identity: A reconceptualization of African American racial identity. *Personality and Social Psychology Review*, *2*(1), 18-39.

Shalev, A. Y. (2002). Treating survivors in the immediate aftermath of traumatic events. *Treating trauma survivors with PTSD*, 157-188.

Shamia, N. A., Thabet, A. A. M., & Vostanis, P. (2015). Exposure to war traumatic experiences, post-traumatic stress disorder and post-traumatic growth among nurses in Gaza. *Journal of psychiatric and mental health nursing*, *22*(10), 749-755.

Shiraev, E. B., & Levy, D. (2015). *Cross-cultural psychology: Critical thinking and contemporary applications*. Routledge.

Shmotkin, D., Shrira, A., Goldberg, S. C., & Palgi, Y. (2011). Resilience and vulnerability among aging Holocaust survivors and their families: An intergenerational overview. *Journal of Intergenerational Relationships*, *9*(1), 7-21.

Shyangwa, P. M., Singh, S., & Khandelwal, S. K. (2003). Knowledge and attitude about mental illness among nursing staff. *Journal of Nepal medical association*, *42*(145), 27-31

Shinebourne, P. (2011). Interpretative Phenomenological Analysis. In N. Frost (ed). Qualitative Research Methods in Psychology: Combining core approaches. Open University. p.44- 65.

Shyangwa, P. M., Singh, S., & Khandelwal, S. K. (2003). Knowledge and attitude about mental illness among nursing staff. *Journal of Nepal medical association*, *42*(145), 27-31.

Siegel, R. L., Miller, K. D., & Jemal, A. (2015). Cancer statistics, 2015. *CA: a cancer journal for clinicians*, *65*(1), 5-29.

Simonds, L. M., & Thorpe, S. J. (2003). Attitudes toward obsessive-compulsive disorders. *Social psychiatry and psychiatric epidemiology*, *38*(6), 331-336.

Singelis, T. M., Triandis, H. C., Bhawuk, D. P., & Gelfand, M. J. (1995). Horizontal and vertical dimensions of individualism and collectivism: A theoretical and measurement refinement. *Cross-cultural research*, *29*(3), 240-275.

Sinha, J. B., & Kumar, R. (2005). Methodology for understanding Indian culture. *The Copenhagen Journal of Asian Studies*, *19*, 89-104.

Sivadas, E., Bruvold, N. T., & Nelson, M. R. (2008). A reduced version of the horizontal and vertical individualism and collectivism scale: A four-country assessment. *Journal of Business Research*, *61*(3), 201-210.

Skorinko, J. L., Lun, J., Sinclair, S., Marotta, S. A., Calanchini, J., & Paris, M. H. (2015). Reducing Prejudice Across Cultures via Social Tuning. *Social Psychological and Personality Science*, *6*(4), 363-372.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health psychology review*, *5*(1), 9-27.

Smith, B. (2015). Mental Illness Stigma in the Media. *Undergraduate Review: A Journal of Undergraduate Student Research*, *16*(1), 50-63.

Smith, V., Reddy, J., Foster, K., Asbury, E. T., & Brooks, J. (2011). Public perceptions, knowledge and stigma towards people with schizophrenia. *Journal of Public Mental Health*, *10*(1), 45-56.

Smith, P. B., Vignoles, V. L., Becker, M., Owe, E., Easterbrook, M. J., Brown, R.,& Yuki, M. (2016). Individual and culture-level components of survey response styles: A multi-level

analysis using cultural models of selfhood. *International Journal of Psychology*, *51*(6), 453-463.

Solomon, Z. (2007). Hashpa'ot bein-doriot shel hasho'ah: Nekudat ham- abat ha'Israelit Bamechkar [Transgenerational effects of the Holocaust: The Israeli research perspective]. In Z.

Solomon & J. Chaitin (Eds.), *Yaldut betzel hasho'ah: Yeladim nitzolim ve'dor sheni* [Childhood in the shadow of the Holocaust–survived children and second generation] (pp. 304–336). Tel-Aviv, Israel: Hakibbutz Hameuchad. (in Hebrew).

Solomon, Z., Greene, T., Ein-Dor, T., Zerach, G., Benyamini, Y., & Ohry, A. (2014). The long-term implications of war captivity for mortality and health. *Journal of behavioural medicine*, *37*(5), 849-859.

Somasundaram, D. (2001). War trauma and psychosocial problems: Patient attendees in Jaffna.

Somasundaram, D. (2014). Addressing collective trauma: Conceptualisations and interventions. *Intervention*, *12*, 43-60.

Sorsdahl, K. R., & Stein, D. J. (2010). Knowledge of and stigma associated with mental disorders in a South African community sample. *The Journal of nervous and mental disease*, *198*(10), 742-747.

Speerforck, S., Schomerus, G., Matschinger, H., & Angermeyer, M. C. (2017). Treatment recommendations for schizophrenia, major depression and alcohol dependence and stigmatizing attitudes of the public: results from a German population survey. *European archives of psychiatry and clinical neuroscience*, *267*(4), 341-350.

Spence, J. T., Deaux, K., & Helmreich, R. L. (1985). Sex roles in contemporary American society. *Handbook of social psychology*, *2*, 149-178.

Spriggs, M., Olsson, C. A., & Hall, W. (2008). How will information about the genetic risk of mental disorders impact on stigma?. *Australian & New Zealand Journal of Psychiatry*, *42*(3), 214-220.

Stangor, C., & Crandall, C. S. (2000). Threat and the social construction of stigma. *The social psychology of stigma*, 62-87.

Stagman, S. M., & Cooper, J. L. (2010). Children's mental health: What every policymaker should know.

Star, S. A. (1955). *The Public's Ideas about Mental Illness: A Paper*. National Opinion Research Center.

Stier, A., & Hinshaw, S. P. (2007). Explicit and implicit stigma against individuals with mental illness. *Australian Psychologist*, *42*(2), 106-117.

Stuart, H., & Arboleda-Florez, J. (2001). Community attitudes toward people with schizophrenia. *Canadian journal of Psychiatry*, *46*(3), 245-252.

Suto, M. (2012). Stigma shrinks my bubble: a qualitative study of understandings and experiences of stigma and bipolar disorder. *Stigma Research and Action*, *2*(2).

Stout, P. A., Villegas, J., & Jennings, N. A. (2004). Images of mental illness in the media: identifying gaps in the research. *Schizophrenia Bulletin*, *30*(3), 543-561.

Stuber, J., Meyer, I., & Link, B. (2008). Stigma, prejudice, discrimination and health. *Social science & medicine (1982)*, *67*(3), 351.

Sztompka, P. (2014). *Agency and Structure (RLE Social Theory): Reorienting Social Theory*. Routledge.

Szmukler, G., Daw, R., & Callard, F. (2014). Mental health law and the UN Convention on the rights of persons with disabilities. *International journal of law and psychiatry*, *37*(3), 245-252.

Štrkalj-Ivezić, S. (2013). Stigma in clinical practice. *Psychiatria Danubina*, *25*(2), 200-202.

Ta, T. M. T., Zieger, A., Schomerus, G., Cao, T. D., Dettling, M., Do, X. T.,& Hahn, E. (2016). Influence of urbanity on perception of mental illness stigma: a population based study in urban and rural Hanoi, Vietnam. *International Journal of Social Psychiatry*, *62*(8), 685-695.

Tabassum, R., Macaskill, A., & Ahmad, I. (2000). Attitudes towards mental health in an urban Pakistani community in the United Kingdom. *International Journal of Social Psychiatry*, *46*(3), 170-181.

Tashakkori, A., & Teddlie, C. (2003b). The past and future of mixed methods research: From data triangulation to mixed model designs. In Tashakkori, A., & C. Teddlie (Eds.), *Handbook of*

Mixed Methods in Social and Behavioural Research. Thousand Oaks, CA: Sage Publications

Tata, S. P., & Leong, F. T. (1994). Individualism-collectivism, social-network orientation, and acculturation as predictors of attitudes toward seeking professional psychological help among Chinese Americans. *Journal of Counseling Psychology*, *41*(3), 280.

Tate, K. (2017). Towards Equitable Placemaking: Incorporating Adaptive Reuse for Cultural Sustainability.

Taylor, S. M., & Dear, M. J. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia bulletin*, *7*(2), 225.

Tate, K. (2017). Towards Equitable Placemaking: Incorporating Adaptive Reuse for Cultural Sustainability.

Tawiah, P. E., Adongo, P. B., & Aikins, M. (2015). Mental health-related stigma and discrimination in Ghana: Experience of patients and their caregivers. *Ghana medical journal*, *49*(1), 30-39.

Teddlie, C. & A. Tashakkori. (2003). Major issues and controversies in the use of mixed methods in the social and behavioural sciences. In Tashakkori, A., & C. Teddlie (Eds.), *Handbook of Mixed Methods in Social and Behavioural Research.* Thousand Oaks, CA: Sage Publications.

Teddlie, C. & A. Tashakkori (2009). *Foundations of Mixed Methods Research.* Thousand Oaks, CA: Sage Publications.

Teney, C., & Subramanian, S. V. (2010). Attitudes toward homosexuals among youth in multiethnic Brussels. *Cross-cultural research*.

Tesfaye, M. (2014). Public stigma against family members of people with mental illness: findings from the Gilgel Gibe Field Research Center (GGFRC), Southwest Ethiopia. *BMC international health and human rights*, *14*(1), 2.

Theophanous, A. (2014). The Cyprus Question and the Role of the UN: An Overall Assessment. *Journal of Modern Hellenism*, *30*, 73-89.

Thomas, C. M., & Morris, S. (2003). Cost of depression among adults in England in 2000. *The British Journal of Psychiatry*, *183*(6), 514-519.

Thornicroft G, Brohan E, Kassam A, Lewis-Holmes E: Reducing stigma and discrimination:

candidate interventions. *Int J Ment Health Syst* 2008, 2(1):3.

Thornton, J. A., & Wahl, O. F. (1996). Impact of a newspaper article on attitudes toward mental illness. *Journal of Community Psychology*, *24*(1), 17-25.

Topkaya, N. (2014). Gender, Self-Stigma, and Public Stigma in Predicting Attitudes toward Psychological Help-Seeking. *Educational Sciences: Theory and Practice*, *14*(2), 480-487.

Torrey, E. F. (1994). Violent behaviour by individuals with serious mental illness. *Psychiatric services*, *45*(7), 653-662.

Torrey, E. F. (2011). Stigma and violence: isn't it time to connect the dots?. *Schizophrenia bulletin*, *37*(5), 892-896.

Triandis, H. C. (1993). Collectivism and individualism as cultural syndromes. *Cross-Cultural Research*, *27*(3-4), 155-180.

Triandis, H. C. (2001). Individualism-collectivism and personality. *Journal of personality*, *69*(6), 907-924

Triandis, H. C., & Suh, E. M. (2002). Cultural influences on personality. *Annual review of psychology*, *53*(1), 133-160.

Tsang, H. W., Angell, B., Corrigan, P. W., Lee, Y. T., Shi, K., Lam, C. S., ... & Fung, K. M. (2007). A cross-cultural study of employers' concerns about hiring people with psychotic disorder: implications for recovery. *Social psychiatry and psychiatric epidemiology*, *42*(9), 723-733.

Tuli, F. (2011). The basis of distinction between qualitative and quantitative research in social science: reflection on ontological, epistemological and methodological perspectives. *Ethiopian Journal of Education and Sciences*, *6*(1).

Turner, J. C. (1999). Some current issues in research on social identity and self-categorization theories. *Social identity: Context, commitment, content*, 6-34.

Tuval-Mashiach, R., Freedman, S., Bargai, N., Boker, R., Hadar, H., & Shalev, A. Y. (2004). Coping with trauma: Narrative and cognitive perspectives. *Psychiatry*, *67*(3), 280-293.

Tziongouros, C., (2007). Retrieved October 25, 2007, from http://www.cypsa.org.cy.

Tzouvara, V. (2015). Self-stigma, loneliness and culture among older adults with mental illness residing in nursing homes.

Türküm, A. S. (2000). College students' attitudes toward seeking psychological help and tendencies of self-disclosure. *Journal of College Education Anadolu University, 10,* 205-220.

Uman, L. S., Chambers, C. T., McGrath, P. J., & Kisely, S. (2008). A systematic review of randomized controlled trials examining psychological interventions for needle-related procedural pain and distress in children and adolescents: An abbreviated Cochrane review. *Journal of pediatric psychology*, *33*(8), 842-854.

Van der Kolk, B. A. (2017). Developmental Trauma Disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric annals*, *35*(5), 401-408.

Ugarte, W. J., Högberg, U., Valladares, E., & Essén, B. (2013). Assessing knowledge, attitudes, and behaviours related to HIV and AIDS in Nicaragua: A community-level perspective. *Sexual & Reproductive Healthcare*, *4*(1), 37-44.

Ukpong, D. I., & Abasiubong, F. (2010). Stigmatising attitudes towards the mentally ill: A survey in a Nigerian university teaching hospital. *South African Journal of Psychiatry*, *16*(2).

Ulin, P. R., Robinson, E. T., & Tolley, E. E. (2012). *Qualitative methods in public health: a field guide for applied research*. John Wiley & Sons.

Uman, L. S., Chambers, C. T., McGrath, P. J., & Kisely, S. (2008). A systematic review of randomized controlled trials examining psychological interventions for needle-related procedural pain and distress in children and adolescents: An abbreviated Cochrane review. *Journal of pediatric psychology*, *33*(8), 842-854.

Unit, S. E. (2004). Mental health and social exclusion.

Unnever, J. D., & Cullen, F. T. (2009). Empathetic identification and punitiveness A middle-range theory of individual differences. *Theoretical Criminology*, *13*(3), 283-312.

Van Dorn, R. A., Swanson, J. W., Elbogen, E. B., & Swartz, M. S. (2005). A comparison of stigmatizing attitudes toward persons with schizophrenia in four stakeholder groups: perceived likelihood of violence and desire for social distance. *Psychiatry: Interpersonal and Biological Processes*, *68*(2), 152-163.

van't Veer, J. T., Kraan, H. F., Drosseart, S. H., & Modde, J. M. (2006). Determinants that shape public attitudes towards the mentally ill. *Social psychiatry and psychiatric epidemiology*, *41*(4), 310-317.

Veerman, A. L. (2001). Computer-supported collaborative learning through argumentation.

Vezzoli, R., Archiati, L., Buizza, C., Pasqualetti, P., Rossi, G., & Pioli, R. (2001). Attitude towards psychiatric patients: a pilot study in a northern Italian town. *European Psychiatry*, *16*(8), 451-458.

Volkan, V. D. (2001). Transgenerational transmissions and chosen traumas: An aspect of large-group identity. *Group Analysis*, *34*(1), 79-97.

Voorend, C. G., Van Brakel, W. H., Cross, H., Augustine, V., & Ebenso, B. (2011). Report of the Stigma Research Workshop for the development of scientific consensus papers and field guidelines on health-related stigma, held in Amsterdam, the Netherlands from 11-14 october 2010. *Lepr Rev*, *82*(2), 188-201.

Wahl, O. F. (2012). Stigma as a barrier to recovery from mental illness. *Trends in cognitive sciences*, *16*(1), 9-10.

Wang, P. S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Borges, G., Bromet, E. J., & Haro, J. M. (2007). Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *The Lancet*, *370*(9590), 841-850.

Wang, P. W., Ko, C. H., Chen, C. S., Yang, Y. H. C., Lin, H. C., Cheng, C. C., & Yen, C. F. (2015). Changes of Explicit and Implicit Stigma in Medical Students during Psychiatric Clerkship. *Academic Psychiatry*, 1-5.

Wang, J., & Lai, D. (2008). The relationship between mental health literacy, personal contacts and personal stigma against depression. *Journal of affective disorders*, *110*(1), 191-196.

Wardi, D. (1992) *Memorial Candles: Children of the Holocaust*. London: Routledge.

Wasserman, D. (Ed.). (2015). *Suicide: an unnecessary death*. Oxford University Press.

Wasserman, D., Hoven, C. W., Wasserman, C., Wall, M., Eisenberg, R., Hadlaczky, G., ... & Bobes, J. (2015). School-based suicide prevention programmes: the SEYLE cluster-randomised, controlled trial. *The Lancet*, *385*(9977), 1536-1544.

Webb, N. B. (Ed.). (2004). *Mass trauma and violence: Helping families and children cope*. Guilford Press.

Webb, E. J., Campbell, D. T., Schwartz, R. D., & Sechrest, L. (1966). *Unobtrusive measures: Nonreactive research in the social sciences* (Vol. 111). Chicago: Rand McNally.

Wedding, D., & Niemiec, R. M. (2014). *Movies and mental illness: Using films to understand psychopathology*. Hogrefe Publishing.

Wei, Y., McGrath, P. J., Hayden, J., & Kutcher, S. (2015). Mental health literacy measures evaluating knowledge, attitudes and help-seeking: a scoping review. *BMC psychiatry*, *15*(1), 1.

Weiss, M. G., Jadhav, S., Raguram, R., Vounatsou, P., & Littlewood, R. (2001). Psychiatric stigma across cultures: local validation in Bangalore and London. *Anthropology & Medicine*, *8*(1), 71-87.

Weiner, B., Perry, R. P., & Magnusson, J. (1988). An attributional analysis of reactions to stigmas. *Journal of personality and social psychology*, *55*(5), 738.

Weiss, M. G., Ramakrishna, J., & Somma, D. (2006). Health-related stigma: Rethinking concepts and interventions 1. *Psychology, health & medicine*, *11*(3), 277-287.

Whaley, A. L. (2001). Cultural mistrust of white mental health clinicians among African Americans with severe mental illness. *American Journal of Orthopsychiatry*, *71*(2), 252.

White, R. G., Ramachandran, P., & Kumar, S. (2017). Addressing Mental Health-related Stigma in a Global Context. In *The Palgrave Handbook of Sociocultural Perspectives on Global Mental Health* (pp. 257-283). Palgrave Macmillan UK.

Whitley, R., & Campbell, R. D. (2014). Stigma, agency and recovery amongst people with severe mental illness. *Social Science & Medicine*, *107*, 1-8.

Williams Jr, R. M. (1947). The reduction of intergroup tensions: a survey of research on problems of ethnic, racial, and religious group relations. *Social Science Research Council Bulletin*.

Williams, M., & Taylor, J. (1995). Mental illness: media perpetuation of stigma. *Contemporary Nurse*, *4*(1), 41-46.

Wimo, A., Jönsson, L., Gustavsson, A., McDaid, D., Ersek, K., Georges, J., ... & Valtonen, H. (2011). The economic impact of dementia in Europe in 2008—cost estimates from the Eurocode project. *International journal of geriatric psychiatry*, *26*(8), 825-832.

Woodward, J. L. (1951). Changing ideas on mental illness and its treatment. *American Sociological Review*, *16*(4), 443-454.

World Health Organization. (2001). *The World Health Report 2001: Mental health: new understanding, new hope*. World Health Organization.

World Health Organization World Mental Health Survey Consortium (2004a). Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys. Journal of the American Medical Association. 291:21

World Health Organization. Regional Office for Europe. (2008). *Policies and practices for mental health in Europe: meeting the challenges*. WHO Regional Office Europe.

World Health Organization. Regional Office for Europe, (2011). *Impact of economic crises on mental health*.

World Health Organization, & World Health Organization. (2014). Geneva. *Downloaded from*.

World Health organization (WHO). (2015). Global Health Risks-Mortality and burden of disease attributable to selected major risks. *The Lancet*.

World Health Organization. (2016). *World health statistics 2016: monitoring health for the SDGs sustainable development goals*. World Health Organization.

Yamaguchi, S., Mino, Y., & Uddin, S. (2011). Strategies and future attempts to reduce stigmatization and increase awareness of mental health problems among young people: a narrative review of educational interventions. *Psychiatry and clinical neurosciences*, *65*(5), 405-415.

Yang, L. H., Kleinman, A., Link, B. G., Phelan, J. C., Lee, S., & Good, B. (2007). Culture and stigma: adding moral experience to stigma theory. *Social science & medicine*, *64*(7), 1524-1535.

Yang, X., & Mak, W. W. (2017). The Differential Moderating Roles of Self-Compassion and Mindfulness in Self-Stigma and Well-Being Among People Living with Mental Illness or HIV. *Mindfulness*, *8*(3), 595-602.

Yang, L. H., Purdie-Vaughns, V., Kotabe, H., Link, B. G., Saw, A., Wong, G., & Phelan, J. C. (2013). Culture, threat, and mental illness stigma: identifying culture-specific threat among Chinese-American groups. *Social Science & Medicine*, *88*, 56-67.

Yanos, P. T., Roe, D., Markus, K., & Lysaker, P. H. (2015). Pathways between internalized stigma and outcomes related to recovery in schizophrenia spectrum disorders. *Psychiatric Services*.

Yesilada, B. (2013). *EU-Turkey relations in the 21st century*. Routledge.

Yuki, M., & Schug, J. (2012). Relational mobility: A socioecological approach to personal relationships.

Zarit, S. H., & Zarit, J. M. (2012). *Mental disorders in older adults: Fundamentals of assessment and treatment*. Guilford Press.

Zeka, J. V. (2015). Cyprus: From an Argued Past to a Shared Future. *European Journal of Sustainable Development*, *4*(2), 141-154.

Zarit, S. H., & Zarit, J. M. (2012). *Mental disorders in older adults: Fundamentals of assessment and treatment*. Guilford Press.

APPENDICES

Appendix 1-Pariticipant Information Sheet

Middlesex University

Psychology Dept., Middlesex University, Town Hall, The Burroughs, Hendon, London NW4 4BT, Akile Zorba

Exploration of Perceptions towards Mental Illness in Turkish and Greek Cypriots living in Cyprus

Name of the Researcher: Akile Berfu Zorba , Academic Year of Study: 2013

We would like to invite you to be part of this research project. You should only agree to take part if you want to, it is entirely up to you. Please read the following information carefully before you decide to take part; this will tell you why the research is being done

and what you will be asked to do if you take part. Please ask if there is anything that is not clear or if you would like more information.

According to Maj et al. (2007), mental illness is very disabling and costly for society, individuals and their families, regardless of ethnicity and race. The aim of this study is to explore the perceptions of Turkish and Greek Cypriot populations about mental health and mental illness. For this purpose the researcher will conduct questionnaires. If you choose to take part in this study I will arrange a time, place and day that best suit you. There are 4 questionnaires for you to complete, this should take around 20-30 minutes.

There are no risks or disadvantages of taking part in this study and the participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part you may withdraw at any time without giving a reason. You will be given a copy of this sheet and will be asked to sign a consent form prior to your participation.

The research is being conducted under the direction of senior researchers. Should you have any concerns or questions about the research, please feel free to talk to the researcher or contact either member of the research team Professor Irena Papadopoulos at ; r.papadopoulos@mdx.ac,uk, +4402084116626 or Dr Nicholas LeBoutillier at n.leboutillier@mdx.ac.uk, +4402084115557

Thank you for reading this information sheet.

Middlesex University, The Burroughs, Town Hall, Hendon, London, NW4 4BT

Contact details of researcher: Akile1@mdx.ac.uk, +447845777491

Declaration of Confidentiality: All records for this project, whether written materials or computer records, will be kept securely. Participants will be identified by a serial number, and not their names. Where information is analysed for publication, only statistical trends will be reported, and there will be no disclosure of individual or identifiable information.*All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. The Middlesex Psychology Department's Ethics Committee have reviewed this proposal.*

Appendix 2: Participant Consent Form

Exploration of Perceptions towards Mental Illness in Turkish and Greek Cypriots living in Cyprus

Middlesex University

Psychology Dept., Middlesex University, Town Hall, The Burroughs, Hendon, London NW4 4BT

Akile Zorba

PARTICIPANT CONSENT FORM

I (name) .....

am happy to take part in the research project by Middlesex University.

I have been told what the study is about and I have read the information sheet, which explains what I have to do. I have asked any questions I might have.

I understand that my name will not be made public in any way in connection with this study.

I know that at any time I can decide not to continue if I do not want to.

Date .....

Appendix 3: Participant Debriefing form

Middlesex University

Psychology Dept., Middlesex University, Town Hall, The Burroughs, Hendon, London NW4 4BT) Akile Zorba

Exploration of Perceptions towards Mental Illness in Turkish and Greek Cypriots living in Cyprus

Around one in four people experience some sort of mental health problems during their life time. In spite of these, high numbers of stigma towards mentally ill individuals exists. There are many factors such as education and exposure that causes stigma towards these

individuals. In order to reduce stigma, one needs to understand the factors that play a role on stigma so that these can be addressed, consequently improving mentally ill individual's quality of life.

The questionnaires you answered included one measurement that is designed to assess attitudes towards mentally ill individuals. It also included familiarity, culture and knowledge scales in order to investigate whether these factors play any role in attitudes. In addition to these interviews included questions on your cultural values and beliefs, perception of mental illness and reasons behind these perceptions.

The purpose of this study was to determine the stigma levels in Turkish and Greek Cypriot communities. It was the researcher's intention to identify any similarities and differences between these two communities such as identity and culture, and to investigate whether or not these had any impact on the shown stigma levels.

We would ask you to maintain confidentiality about the purpose of the study since any pre-knowledge of the purpose will bias the data for other participants and thus cannot be used. This issues involved in this study are complicated and you may have found it difficult to answer some questions. Your willingness to participate in this study, however, made it easier for the researcher and it is greatly appreciated. Your input will contribute to the improvement of the field of mental illness stigma. Some individuals may find some of the questions disturbing and if at any stage of this study you felt uncomfortable and would like to speak to someone about this please contact one of the following; Northern Cyprus: Lepim Klinik, Lefkoşa,Tel: +90 (392) 2252352, Southern Cyprus: Cyprus Samartians Helpline ,Telephone: 80007773, Email: confidential@cyprussamaritans.org

If you have any complaints, concerns, or questions about this research, please feel free to contact the supervisory team, Professor Irena Papadopoulos at; r.papadopoulos@mdx.ac,uk, +4402084116626 or Dr Nicholas LeBoutillier at n.leboutillier@mdx.ac.uk, +4402084115557.

Thank you very much for participating!

Appendix 4: Demographic Form

Demographic Information

Sex

Male	Female	Other (Please Specify)
☐	☐	

Age

18-25	25-35	36-50	51-65	66-Above
☐	☐	☐	☐	☐

Ethnic Origin

Greek (Greece Born) ☐

Greek (Cyprus Born) ☐

Greek Speaking Cypriot ☐

Turkish (Turkey Born) ☐

Turkish (Cyprus Born) ☐

Turkish Speaking Cypriot ☐

Other (Please Specify)

Highest Educational Level:

Occupation:

Email Address or Mobile Number:

Appendix 5: Knowledge Questionnaire

Vignettes

Vignette A

X is a 21 year old who lives with his parents. He started going to university last year and became very shy and only managed to make one friend. He says that he wants to make more friends but he is scared that he will do/say something silly when he is with others. His grades are ok but he does not speak much in class, he is very nervous, he shivers, blushes and feels physically ill, if he is asked to speak infornt of the class. He is very talkative with his family at home, however, he feels

very uncomfortable if someone he does not know comes over. He does know that his fears are not reasonable, however, he says that he cannot control them which is very upsetting for him.

Vignette B

X is a man who is very suspicious, does not trust anybody and thinks everybody is against him. Sometimes, he might think that people on the street is talking about him and following him. Several times he had an argument with the people saying they were talking about him and trying to trick him. Several days ago it happened again and he thought that his brother was against him and started to swear at his brother. He then threatened to kill him.

Questions

Do you think the individual described has a mental health disorder?

Yes No Undecided

1. Could you please indicate the disorder?

1. General Life stress
2. Depression
3. Schizophrenia
4. Social phobia/anxiety disorder
5. Panic disorder
6. Personality disorder
7. Medical problem
8. Other (please indicate)

2. What do you think is the main reason for the problem?

1. Stress
2. Biological problems
3. Mental illness
4. Personality Weakness
5. Environmental Factors
6. Other (please indicate)

3. Do you think this person should seek professional help for this problem?

1. No
2. Yes
3. Undecided

4. How difficult is it to treat the condition?

1. Not at all
2. Somehow
3. Extremely

5.If this person was your friend what would you recommend that she/he does? (list as many as possible)

Appendix 6: Level of Contact Report

Level-of-Contact Report (LCR) (Hackler, 2011)

A mental disorder or mental illness is a psychological or behavioural pattern that occurs in an individual and is thought to cause distress or disability.

Please keep this definition in mind as you respond to the following questions. Please read each of the following statements carefully and place a check by each statement that is true for you.

1=Yes

2 =No

1. I have watched a movie or television show in which a character depicted a person with mental illness.

2. My job involves providing services/treatment for persons with a mental illness.

3. I have observed, in passing, a person I believe may have had a mental illness.

4. I have observed persons with a mental illness on a frequent basis.

5. I have a mental illness.

6. I have worked with a person who had a mental illness at my place of employment.

7. I have never observed a person that I was aware had a mental illness.

8. A friend of the family has a mental illness.

9. I have a relative who has a mental illness.

10. I have watched a documentary on the television about mental illness.

11. I live with a person who has a mental illness.

Appendix 7: The Attitude Questionnaire

The Attitude Questionnaire (AQ, Corrigan et al)

Please circle, underline, or fill in the box for the answer which best reflects your opinion of the individual in the video clip you just viewed.

1. I would feel aggravated by X.

   not at all 1 2 3 4 5 6 7 8 9 very much

2. I would feel unsafe around X.

not at all 1 2 3 4 5 6 7 8 9 very much

3. X would terrify me.

not at all 1 2 3 4 5 6 7 8 9 very much

4. How angry would you feel at X?

not at all 1 2 3 4 5 6 7 8 9 very much

5. If I were in charge of X's treatment, I would require him to take his medication.

not at all 1 2 3 4 5 6 7 8 9 very much

6. I think X poses a risk to his neighbours unless he is hospitalized.

not at all 1 2 3 4 5 6 7 8 9 very much

7. If I were an employer, I would interview X for a job.

not likely 1 2 3 4 5 6 7 8 9 very likely

8. I would be willing to talk to X about his problems.

not at all 1 2 3 4 5 6 7 8 9 very much

9. I would feel pity for X.

not at all 1 2 3 4 5 6 7 8 9 very much

10. I would think that it was X's own fault that he is in the present condition.

not at all 1 2 3 4 5 6 7 8 9 very much

11. How controllable, do you think, is the cause of X's present condition?

not at all under personal control 1 2 3 4 5 6 7 8 9 very much

12. How irritated would you feel by X?

not at all 1 2 3 4 5 6 7 8 9 very much

13. How dangerous would you feel X is?

not at all 1 2 3 4 5 6 7 8 9 very much

14. How much do you agree that X should be forced into treatment with his doctor even if he does not want to?

not at all 1 2 3 4 5 6 7 8 9 very much

15. I think it would be best for X's community if he were put away in a psychiatric hospital.

not at all 1 2 3 4 5 6 7 8 9 very much

16. I would share a car pool with X every day.

not at all 1 2 3 4 5 6 7 8 9 very much

17. How much do you think an asylum, where X can be kept away from his neighbours, is the best place for him?

not at all 1 2 3 4 5 6 7 8 9 very much

18. I would feel threatened by X.

not at all 1 2 3 4 5 6 7 8 9 very much

19. How scared of X would you feel?

not at all 1 2 3 4 5 6 7 8 9 very much

20. How likely is it that you would help X?

not at all 1 2 3 4 5 6 7 8 9 very much

21. How certain would you feel that you would help X?

not at all 1 2 3 4 5 6 7 8 9 very much

22. How much sympathy would you feel for X?

not at all 1 2 3 4 5 6 7 8 9 very much

23. How responsible, do you think, is X for his present condition?

not at all 1 2 3 4 5 6 7 8 9 very much

24. How frightened of X would you feel?

not at all 1 2 3 4 5 6 7 8 9 very much

25. If I were in charge of X's treatment, I would force him to live in a group home.

not at all 1 2 3 4 5 6 7 8 9 very much

26. If I were a landlord, I probably would rent an apartment to X.

not at all 1 2 3 4 5 6 7 8 9 very much

27. How much concern would you feel for X?

not at all 1 2 3 4 5 6 7 8 9 very much

Appendix 8: Cultural Orientation Scale

Horizontal and Vertical Individualism and Collectivism Scale

Horizontal individualism

1. I'd rather depend on myself than others.

2. I rely on myself most of the time; I rarely rely on others.

3. I often do "my own thing."

4. My personal identity, independent of others, is very important to me.

Vertical individualism

1. It is important that I do my job better than others.
2. Winning is everything.
3. Competition is the law of nature.
4. When another person does better than I do, I get tense and aroused.

Horizontal collectivism

1. If a co-worker gets a prize, I would feel proud.
2. The well-being of my co-workers is important to me.
3. To me, pleasure is spending time with others.
4. I feel good when I cooperate with others.

Vertical collectivism

1. Parents and children must stay together as much as possible.
2. It is my duty to take care of my family, even when I have to sacrifice what I want.
3. Family members should stick together, no matter what sacrifices are required.
4. It is important to me that I respect the decisions made by my groups.

Appendix 9: Interview Transcripts

Ilmiye's Interview Transcript

(55, TC, Teacher)

Interviewer: Can you tell me about your culture?

Interviewee: Mmmm our culture involves our family and traditions. We are very friendly you know we will welcome any one into our houses. It is our culture we call it "misafirperverlik". Cypriot women who live in this part have a coffee tradition for example, every morning they will

gather around and have their coffee together and gossip. Our people like to spend time with each other.

Interviewer: Ok since you mentioned the family first let's start with the familial relationship. Can you describe to me how familial relationships are in Cyprus?

Interviewee: To us family is very important. My parents, sisters and a brother we are always getting together, we like to spend time with eachother. My kids are like that as well they enjoy going to their grandparent's house. We try to have barbecue once a week all together so that we can see eachother. I always pass by my mother's house after work to check on them. They are getting old so it is important that we take care of them. So like we are very connected as a family I will say.

Interviewer: hmm

Interviewee: it is important to be like this you know. We went through a lot like I mean without my family I do not know how I would have survived. You know we had been through a lot, we saw war but we remained together as a family. To Cypriot parents, their children are everything. They will take care of them from birth till the end of their lives. I have children who are now working but I still support them. They live with me, I cook, wash and clean for them. It is our duty to do that as a family. Even when they get married this will continue. Like my children we used to drop them to either my husband's family or mine when they were small so that they were taken care of when we were at work. They prepared our meals on our return from work as well. So family unit is strong. It is like this for many Cypriots. They bought us this house and they did not ask for the money. In fact when we offered it was like an insult to them. I owe a lot to my family. It is a Cypriot thing, I mean I cannot imagine an American family who will do this.

Interviewer: It sounds like you have a great family. Is it the case for every TC to have familial relationships like this?

Interviewee: I would think so. I mean we were brought up like this you know. Family always stays together no matter what. That is what we are thought from a young age.

Interviewer: How about others, I mean the relationship amongst the other members of your community?

Interviewee: It is a small place so how disconnected can it be (laughs). You cannot really have bad relationship with each other in this small place. I would say as a TC community we are very close. I think it is also because we have been assimilated so there is less of us in our island now so we feel like we need to support each other even more now. I would say that it is not like the relationship that I have with my family but it is pretty close. Like for example I would have my coffee with the neighbours everyday. I know what goes on their lives and they know what goes on in my life. We help and support eachother when we have difficulties. Like the other week neighbour had a construction work in her house that lasted for a week. They ate in our house every night. They took their shower in my house. It is like that with us. I cannot say no to them and they would not say no to me.

Interviewer: I see.

Interviewee: They are very friendly. You know everyone knows everyone in here so you have to be nice to each other. Even if they do not know you they will treat you nice. People will go out of their way to help each other. I am not sure if there is another country like us. You are a Cypriot like me and you know how things work in here. If you want to get a job you have to know someone, if you want to get things done anywhere like in banks, schools, and governmental places especially it will be much easier for you if you know someone in that particular place.

Interviewer: hmmm

Interviewee: do you see what I mean when I say I am not sure if a place like ours exist in the world? I mean if you don't have good relationships, if you do not know people you should then nothing gets done in here. We call this "ahpab işi" which basically means that if I know you I will support you and do whatever you ask me to do. Like the other day I went to get my blood test done at the hospital and their shift normally ends at 12:00 pm. But due to work I went there at around 14:00 pm. I spoke to my friend who knew one of the nurses and thankfully she took my blood. In our public hospitals you are supposed to get a number and queue up to be seen even for a blood test. But if you know the doctor somehow may be through someone else or personally you get to be seen first, even without a number.

Interviewer: What do you mean by 'the people you are supposed to know'?

Interviewee: I mean those who can get things done for you. In every place there are different people that you need to know. Like if you have something to do with the government, even to get a simple document you can call your friend who works in a governmental job and get it the same day of your application instead of waiting for a month. It works like this in this island.

Interviewer: OK. So it looks like in your culture people tend to help eachother quite a lot.

Interviewee: Yes people are quite involved in others' lives. I mean it is a small place so you hear about everything from everyone. There are limited places to go so when you go out people you see are the same, people you talk are the same.

Interviewer: Ok. Thank you for talking to me about your culture. I now want to talk about how these values which you mentioned earlier such as the strong support you have amongst the society and how these values may be influencing TCs' perceptions on mental illness.
Interviewee: I mean when you say mental illness do you mean the people in hospital?

Interviewer: Both in the hospital and those who receive their treatment as out-patients.

Interviewee: I mean I do not know many who receive it at home but when you say mental illness our community can unfortunately be quite harsh. It is not something that we can talk about much. I think it is the first time somebody asked me about this and I am 55! (Laughs)

Interviewee: I will support these individuals but most would not.

Interviewer: hmm, what would the majority do?

Interviewee: Some make fun of them like they are a source of fun in our society. You know people call them funny names like crazy, stupid or childlike. I am against it but generally that is what happens. We can say that in our society people have no respect for those with mental illnesses. They see it as it's the person's fault. Like depression for example they will call you 'nane mulla' which means you over react to everything and get upset for no reason. It is almost like society treats them as if it is their fault and they do not understand anything or have no feelings.

Interviewer: I see**.** Can you explain what nane mulla is?

Interviewee: Nanemulla is a word we use for these who have a very sensitive character. These people generally get very emotional and upset over little things. Its how they are you know. I am not like that for example I am tough, I do not get upset very easily and even if I do I would not show it. Like being upset even when there is no reason to be, I think it's to do with their character they are just not as strong. When you get upset over everything its no wonder that you will experience depression. If they just go out and socialise I think it will be OK.

Interviewer: So can we say that if people with depression go out more they will feel better.

Interviewee: Yes! When you go out you see people and you can talk to them about your problems. May be this way they can see that what they are getting upset about is not worth it. You know I think sometimes, especially in our society families are over protective of their children. Like I am as well but I also let my children face their own challenges. If I did not they probably would become sensitive 'nanemulla' as well. So unfortunately sometimes children pay the price of their families fault.

Interviewer: What do you mean by that?

Interviewee: I mean because parents can be quite protective they raise their children in a buble. As a teacher I see it in my own work. Some children think they are the princesses and princes and I think this is wrong. When they grow up and realise this is not the case and the world does not evolve aroud them. But at that age they cannot deal with it so they become mentally ill. It's not their fault but it is their parents' fault.

Interviewer: Oh ok. So do you think that the Cypriot cultural values have anything to do with these?

Interviewee: Of course! We are a small community and having a good name is quite important for us.

Interwiever: What do you mean by a good name?

Interviewee: Like a well known name for doing good things; being honest, working hard, being strong and helping others. That is also why we prioritise our children.

Interviewer: What do you mean?

Interviewee: I mean when I get together with my friends we mainly talk about our children and their achievements. Like mine went to this university/ mine is a doctor/ mine is a lawyer, you got the idea. We invest so much to our children so that they can carry on our good family name.

Interviewer: How do they do it?

Interviewee: The way they talk, they way they behave, their education their work is all a representation of us. It is our way of showing off to everyone (laughs). I do not mean it in a bad way, it is not like we push them. They want to do it to please us. I was like that my parents wanted me to be a teacher so I went for it. I wanted to go to Turkey and become a hostess but my parents did not allow me. I mean we did not have that much money as well but I could have got a scholarship. My dad said he would miss me and my mum would have lost her mind out of worry every time I fly (laughs). I was a young girl so I could not resist. So it is like that when our children are small we send them to very prestigious schools so that they can find better jobs in the future.

Interviewer: I see. So you mentioned that your children carry on the good family name by behaving well and completing their educations. What about individuals with mental illness?

Interviewee: But when people do not say no to their children they become spoilt and instead of becoming the person that their parents imagined they loose their minds. As a result they are made fun. This also applies to their families you know.

Interviewer: I see. So are families going to be ashamed for not bringing up their children appropriately?

Interviewee: Absolutely! We have only one expectation from our kids, it is to make us proud by being a good member of the community by working. The other things like money we deal with. We provide everything and give them the opportunities we did not have at the time like going abroad for education. When the child does not grow up to be as expected families will therefore be blamed for it.

Interviewer: hmm.

Interviewee: Like sometimes its not the parents' fault some are born like that. It is in their families' blood and you cannot do anything about it. You are stuck with it for the rest of your life. I mean I do not know.

Interviewer: Can you expand on it more? What do you mean stuck with the person for the rest of his/her life?

Interviewee: Well I have not spoken to anyone with such conditions. I do not know where they are, we do not have much awareness because such issues are not spoken in our society. It is like if you have it, this will be dishonouring you as a person and also your family so you keep it hidden as much as you can. Because our children carry on the family name if something like this happens this will be stuck with the person as well as the family for a long time. Although Cypriot people are friendly when things like this happen they talk. Gossip is a big thing in our society. You know what I mean, most of the time people just talk and criticise even for no reason.

.**Interviewer:** Ok, I understand. How do families keep individuals with mental illness hidden?

Interviewee: If someone has a family member with such problem for example they will need to take full control of the individual's lives like treatment, employment, housing, food. If the family member cannot take control then they will go into the hospital in Nicosia so they do not have much

choice. I cannot imagine a Cypriot family sending their kids to the hospital so they will try to put up with their behaviour first and if it is out control and the person is being violent then I thinks that is when they should send them there.

Interviewer: Do you think that individuals with mental illness can be violent?

Interviewee: I mean, yes because they can change in a second.

Interviewer: What do you mean by that?

Interviewee: I mean like one moment they are happy, the next moment they are sad. So you cannot foresee their behaviour. They can be violent and when they are like this, I mean when families cannot handle them then they are put into the hospitals and I feel sorry for them because they are locked there. Not like they cannot go out or something but they are restricted. They have to stay there, I can empathise but that is for their own benefit.

Interviewer: So do you think that hospitalising these individuals benefit them?

Interviewee: Yes I think so, because they get treatment there. They can be given their medication on a regular basis, which calms them down. I mean we see them on the street sometimes near the main hospital. They are allowed out during the day but because they are medicated they are calm. They ask for food, money or cigarettes people will buy it for them and send them away.

Interviewer: Ok, so you mention that individuals with mental illness can be violent. do you thnink that males view them the same? Or is it just women>

I**nterviewee**:Hmmm I do not think so. I think like if you compare me and my husband, I am generally more careful about the situation. Like in traffic I go slowly I feel like I am more carefull because I watch out for things. I do not know may be it is because I am a mother and I have been conditioned to do that (Laughs).

Interviewer: Can you expand on this?

Interviewee: You will understand it when you have children. When you have kids it is different you need to make sure that they are safe so like when they were small I used to watch the surroundings a lot to keep them safe. I still do it when they are around. Like when they have friends I have to check them and their faily out etc. My husband is not like thah. He is more relaxed. I mean he cares but I think it is a man thing.

Interviewer: So as a mother you feel as if you have to check the environment to see if it is safe for your kids.

Interviewee: Yes and like if I do not know what the person is capable of doing I will be uncomfortable in that situation/

Interviewer: So when you see people with mental illness on the streets will you feel uncomfortable?

Interviewee: Yes, like not in a bad way but if they ask me to buy something I will aslo buy it for them. I will donate clothes if I can. I mean they are like children even a chocolate bar will make them happy. But I would not like stay there for a long time.

Interviewers: I see. Ok so if they can be dangerous why do you think they are allowed out in the public?

Interviewee: Our government lacks control. Just as they cannot control anything this is also a problem. Like from what I observed some of these people cannot talk properly, some of them rock back and forth constantly they are all different and I do not know which one is capable of doing what. I do not know may be the ones who we see are checked and they are not dangerous, I am not sure. Like you never know with them.

Interviewer: Ok. Earlier in your interview you mentioned that although public makes fun of these individuals you disagree with it. Do you think this attitude need to change?

Interviewee: Yes of course I mean after all they are human.

Interviewer: What can and should be done in order to change these attitudes?

Interviewee: I mean there are lots of things that need to be done. Like we need to educate kids, families… hmm..Let me think for a bit.

Interviewer: Sure take your time.

Interviewee: I think the hospital, where they stay needs to be renovated. We hear stories about that place and it sounds quite bad. Like some sleep on the floor, some fight with each other. So the place needs to be controlled and may be more people could be employed.

Interviewer: Where do you hear about these things?

Interviewee: I heard it on the news. I cannot remember when but I heard that people in there were not living under good conditions.

Interviewer: Ok.

Interviewee: But I think we must first begin with getting to know these individuals. We must pay attention to who they are?, what they do?, where they live? and how they live? We need to try interacting with these individuals. May be go to the hospital and visit them so that we can see them. I think if we get to know these people we will be in a better position to make up our own minds about them rather than just relying on media and other people which can be negative sometimes. I mean Cypriot people are so welcoming it is just that we do not know these conditions well so once we get to know them I think our perceptions and attitudes will change. I think educating kids from an early age is also important so that they know what mental illness is.

Interviewer: Anything else you can think of?

Interviewee: Like may be professionals can come and give us speech in schools, we get lots of information for things like cancer and diabetes but mental illness is never mentioned. No body explained to us what it is etc. So I think professionals can come to schools and they can talk to the parents and kids as well. Like we have cancer awareness days, diabetes awareness days that we organise in schools. This could be also one of the things that we do. This way I think we will have more awareness.

Interviewer: These ideas all sound very lovely. Anything else that you can think of?

Interviewee: No because I am a teacher I can only think what can be done in schools (laughs). I mean when I think about it I am 55 and nobody talked to me about mental illness. As soon as we hit 45 people start talking about breast cancer for example so like right now I know what it is, what may cause it, how to check for it, and when to check for it. If I suspect anything I know who to speak to and I share this information with my daughter too. Although she is young, she at least knows. Mental illness is not like this like if I knew I could have shared it with my children as well but because I do not have any information I cannot talk to them about it.

Interviewer: You are right. So you think informing the public, parents and the kids are **important.**

Interviewee: Absolutely. I think that is the only way.

Interviewer: You have a great help thank you so much for spearing some time to talk to me today. Do you have any questions?

Interviewee: It is not a problem, my pleasure I really like helping young people with their studies. I wish you best of luck.
Interviewer: Thank you.

Reflexive Journal- Ilmiye's Interview

This reflexive diary will be kept in an effort to reflect and learn from the experiences, which I gained as a PhD student and a researcher conducting qualitative study.

Ilmiye (55. TC. Teacher) was the first participant whom I interviewed and this part of the diary reflects on my experiences as an interviewer. I accept interview as a process that allows meanings to be created between an interviewee and interviewer. The interaction between my participant and me, therefore, is very important for the creation of such meanings. This being said it is important that I reflect on my background as an interviewer. As a PhD student, I started my data collection for the quantitative part of this project in 2014. During my first meeting with some of the Turkish and Greek speaking participants I was questioned by some of them for referring to them as either being Greek or Turkish on the information and consent forms. At the time they emphasized on being only Cypriot who speak either Greek or Turkish and I felt that perhaps as a researcher I did not think of this thoroughly and offended some of my participants which was an experience to learn

from. There on I changed and edited the necessary forms to avoid such situation. Nonetheless, this bitter experience instilled within me that although without an intention one can offend the participant. In conducting interviews for my PhD thesis I feared of this particularly during my first interview, considering the sensitive topics as war, mental illness and ethnicity were touched on. I did not want to offend my participant in anyway nor did I want to influence her views. Thus in this interview I tried to focus on asking only the interview questions, being attentive to what Ilmiye was saying but not sharing my views and not responding to statements as "You do agree yes?" or "You know how it is" which she sometimes used throughout her interview. I felt that she sometimes sought my approval by using these statements, however, I feared that responding to these might interfere with her thoughts and change the meanings, which she created though her experiences. This was what I was interested in learning. For this reason I tried to only focus on asking my interview questions and using prompts when necessary to gain an in depth understanding of the different concepts we discussed. I only brought a notepad and a recorder to the interview. The notepad included my interview questions and the recorder was used to record the interview following Ilmiye's consent. Having the questions and prompts during the interview gave me comfort as I feared of forgetting my questions and having awkward silence thinking that it would create a perception about me being inexperienced and lacking skills as a researcher and an interviewer. As we were sitting facing each other Ilmiye was able to see the interview questions, which I was also concerned about, as I did not want her to think that this was a Question and Answer type of an interview as this could have prevented her to give me a detailed account of her experiences. I was genuinely interested in what she had to say. I, therefore, consciously tried to limit myself from looking at my notepad and preparing for the interview, the night before by going over the questions helped me to relax and not refer to the notepad so often.

During the first part of the interview, my aim was to understand Ilmiye's culture so I asked questions focusing on description of this. This encountered several obstacles. As the interview went on it became clear that Ilmiye was overly focusing on her family and upbringing, which of course was important in the discussion of culture but I was also interested in other things as relationships within the community members and the outsiders. I felt challenged in a sense that I did not want to stop her because she was so very much proud of her children and her own parents so I thought that changing the subject might offend her. For this reason I waited for her to finish talking about her family, then asked her about other things. The second part of the interview focused on her perceptions about mental illness and those with mental health problems. As Ilmiye was a Turkish speaking Cypriot participant most of the things, she referred to was familiar to me and during the interview this concerned me in a way that I believed I could have missed something important in between. So, I made sure that I listened to her very carefully and asked her to explain some of the concepts even though I was familiar with them. For example, the term "Nane Mulla" was brought up by Ilmiye. Although I am familiar with this term and knew the meaning of it I still asked her to explain it to me, as I believed that there might be differences between our perceptions about who is nane mulla and who is not. I am glad I

did this as I found out that there was a difference between us. While Ilmiye used this term to define an individual with depression, I would have never associated this term with someone who has depression as I generally use it to define an individual who is spoilt.

Most of the things Ilmiye talked about as parents being protective, families having a strong bond, expectations from the children were things that I could relate to as well and I think it gave me an assurance that these things are important and likely to come up again during my interviews with other participants.

Before I started, I was worried about whether I would be able to find common themes between my participants but now that I completed one of the interviews, I feel more assured of this. I should also mention that in some parts of the interview particularly when we started to talk about individuals with mental illness and how they are perceived and treated, I sometimes felt upset and ashamed as well. Particularly when Ilmiye said it is something that you are stuck with. When I heard that I felt the need to ask her to clarify it and I felt as if mental illness is something so bad and so if someone has it, it is like a death sentence for that individual. Although I expected some negativity, I could not believe the great extend of negativity that surrounded mental illness at this century in my own community. I believe that before our interview my expectation was higher for Ilmiye as she was a teacher. I automatically assumed that she would be more knowledgeable, tolerant and compassionate towards individuals with mental illness because to me that is how teachers should be; always understanding. Not interfering was hard but important for me to let my participant speak freely so that is what I did. Listening to the interview again and noting down my experiences helped my stop my biases I held about the participant, which I was not even aware of before the interview.

Finally, Ilmiye wanted to receive feedback from me about how she did once we finished the interview. I was surprised that she asked me whether she answered the questions OK or not. As this was not an exam, I told her that I am not able to give her this kind of feedback. However, I told her what I thought; that I believe she helped me a lot with her answers her calm and relaxed approach to the interview process also enabled me to remain calm and that benefited the interview process.

Through this experience, I learnt that the research process does not proceed by the book, as it is a production of my interaction with the participant. It served as a reflective arena for Ilmiye to talk about her experiences and for me to reflect on the findings of my overall PhD studies. I was worried about many things as this was my first interview and I wanted it to be as it was written in the textbook. However, I soon realised that real life is quite different. I sometimes could not stop Ilmiye or change the subject so I let her talk more than I initially planned, I sometimes felt uneasy when we were talking about mental health and illness and I wondered if this was acceptable for a researcher. I, however, regarded these as my reflexive experiences, which I gained in this interview that I believe, made me more open minded and unbiased in my analysis.

Andreas's Interview Transcript

(GC, Lawyer, Male, 58)

Interviewer: Can you tell me about your culture?

Interviewee: Hmm my culture. To us Cypriots our family, our food and our traditions are very important. We enjoy spending time with our family, eating, drinking and dancing. We are very relaxed as a society. Women hang out at homes drinking coffee with their neighbours. Like my wife, she is a house maker so every morning she goes to someone's house and once a week it is her turn to be the host. That day I am kicked out of the house as well (laughs). When I get time, I sometimes hang out in a local coffee shop, although its generally for older people sometimes I see people that I know so I sit around and chat with them.

Interviewer: Hmm.

Interviewee: Like before it was more beautiful when I was younger our people were different things are changing now.

Interviewer: Can you expand on it more?

Interviewee: I mean it is still a beautiful culture. We enjoy our time with family, we enjoy our food, to drink and dance. But you know it started to change because now people are too busy and we really only have little time to even spend with our family.

Interviewer: So compared to old time people are more busy and even the family members cannot spend much time together?

Interviewee: Yes, people work now. Our children start getting jobs at the age of 16.It is not that they need money but you know they want to be 'grown ups'. When they earn money they can be more independent from their families.

Interviewee: Oh I see. How does that compare to when you were younger.

Interviewer: When I was younger we had bigger problems like war, so we had to support our families. But even then families were very close to each other. Not just paretns and the children, I remember my uncles, aunts, my cousins and grandparents all together. We used to live and do everything together at the time. We had fields that we grew vegetables and although every family had their share they were still working on it together. It is not like this anymore.

Interviewee: Ok. How is the younger generation now apart from not being as close to the extended family?

Interviewee: Not even extended family, they do not know their great aunts and uncles. I mean we do not have as much time to go visit them so it is not surprising. The communal living does not exist anymore everybody has their own house and minds their own business.

Interviewer: S can we say that people are becoming more independent?

Interviewee: Yes we are better but the younger generation like my kids and the ones after them I think. They now have more time to spend with their friends than us. They become hard to please, they are more independent. When I was a child we used to live in Paphos and my mother did not even send me to Nicosia for schooling because she found it too far. In my time family stayed

together and also the neighbours were very close. We knew everyone in where we lived our community was our big family. Now my kids do not even want to go visit their family once a week, they do not know their 2nd-3rd cousins, they are becoming more independent and disconnected from their family. They rather go to a coffee shop and meet with their friends. They have got their own things to do and I mean I do not blame them they need to work and are busy but I miss those days where we used to have a big family gathering, long tables with full of food and everyone together.'

Interviewer: How was your relationship with your parents compared to your children and you?

Interviewee: Very different I can tell you (laughs). We had more respect for our parents. We could not say no to them when they asked us for something. But the new generation is not like that they are more likely to discuss their own opinions. We used to be quite when around with grown ups now even the small children talk about their own ideas, it is amazing.

Interviewer: Why do you think this change had happened?

Interviewee: As a society we changed I think and I think we are changing as a society partly because of globalisation. I mean we have to, otherwise you cannot keep up. Now we are integrating more with others, big businesses from all over the world are opening up. You can even go to a supermarket and shop for groceries that are shipped from UK. So we are now more open, more aware of others and our world in general.

Interviewer: I see so globalisation and development of the community had resulted in some societal changes?

Interviewer: Yes I mean we must understand the new generation. They have to be independent and under these conditions where they work from morning until night it is not easy to spare time to your family as much.

Interviewee: I mean when I was their age yes I worked the whole day as well but my wife was at home so she did everything like taking care of the children, cooking, cleaning. My mum used to stay with us as well so she helped. But now everybody needs to work yes getting things is easy but you have to work so that you can afford it. So times are changing.

Interviewee: Ok. Thank you for that. We talked a lot about the family and relationship amongst the members. I am also interested in how the relationship amongst the community members is. Can you tell me a bit about it?

Interviewee: Hmm. sure I mean we are Cypriot so we like to talk and I would say we are very friendly. People are generally helpful and nice to each other but again its not like the old times.

Interviewer: For example you mentioned your wife and how she has coffee with her neighbours every morning. Is it the norm?

Interviewee: It used to be but most of the people work now like I cannot imagine my daughter doing this. Before the community members lived very closely. Everybody was aware of what was going on in other person's life. Now its not like that everybody goes to work and minds their own business. I mean we still like to get together but I suppose its not as much as before.

Interviewer: I understand.

Interviewee: I mean we have lits of foreigners as well now so the community is not as pure You know what I mean.

Interviewer: hi-hi

Interviewee: You get people from Russia, England, and Philippines as your neighbours so it is not like we are all Cypriots now. We live in Cyprus but we are different. They do not know our tradition and we do not know theirs so it is not as easy to have those old relationships.

Interviewer: I see so now that you have different individuals from different cultures, the old relationships which you had with your Cypriot neighbours is not as common.

Interviewer: Ok. Thank you for talking to me about your culture. I now want to talk about how these values, which you mentioned earlier such as the changing the traditions, may be influencing GCs' perceptions of mental illness.
Interviewee: That is a tough question (Laughs)

Interviewee: I think these people still live in isolation and are scared to talk about their condition because they think others will not understand. Sometimes you get really rude people. For example in some supermarkets we have people with different disabilities and are employed there to pack shopping bags. I do like seeing them do something and I do support it I even give extra money to them sometimes.

Interviewer: Do you try helping them in other way?

Interviewee: I mean I speak to them I ask how they are doing and have a little chat. It makes them quite happy. One of them knows me so when I go into the shop he comes and hugs me.

Interviewer: That is quite nice. Do you think others act like you as well?

Interviewee: Unfortunately I cannot say that as I have witnessed some people refusing to allow them pack their bags. I do not know may be they think that they are not clean or something. It is a shame and I think we need to be more supportive of these individuals.

Interviewer: Oh I see. Why do you think is that?

Interviewee: I mean Us Cypriots pay too much attention to what other people say about us and our family. To us family is very important so for example anything that I do has a consequence on my own family. Unfortunately because mental health problems are not accepted in our society because they cause problems such conditions are hidden away to avoid damaging family's reputation.

Interviewer: What do you mean by 'family's reputation?

Interviewee: Like if you tell my name in my village people will talk about me very highly because I am a lawyer and I have good relationships with people. Thankfully I also do not have mental illness. Like if I did for example I do not think people will be saying so much nice things about me and this will influence my wife, my children, and my grandchildren.

Interviewer: So having a mental illness potentially has mad consequences on individuals as well as the families.

Interviewee: Oh yes. I mean mental illness is a different thing, people do not really like to talk about this and do not view it as an acceptable condition to have, like I do not know, like diabetes but this must change. He also argued that 'I mean it is something that everybody can have, do you see what I mean? I can have it, you can have it. You know we had such a bad time in this island in 1974 and recently in 2013. Lots of people have lost their relatives, their jobs, their houses so I think in Cyprus everyone has some sort of a trauma because look at our history. It is just some people feel it more so they need help. I try to help these people as much as I can but these things are not really talked about in public freely. I know because I have a close relative with mental illness.

Interviewer: I see so can you tell me about how people with mental illness are treated in your community?

Interviewee: I think it is getting better with time. Like in old times people used to be not so nice about it, they felt ashamed and did not want to even acknowledge that they have someone around them in their families with mental illness. There is still hesitancy and shame that surrounds such conditions but I think now we are more understanding. At least I am and I think it is because we now have more awareness of these issues and also very recently we have had an economic crisis where most of us were badly influenced so people can actually empathise more with those going through bad times.

Interviewer: So you mentioned that you now have more awareness about these issues. Can you tell me how you became aware?

Interviewee: As I said I have a friend so that helped me a lot to see what mental illness truly is. Can I tell you about what he has?

Interviewer: Yes but please do not mention his name.

Interviewee: Yes of course. My friend has bipolar you know these people who have constant mood swings. I think for him to open up to me about it was a big step to take. It showed me that it was not something to be scared off. Like before I was not scared but people generally have that idea about mental illness that these people can be violent. But to me once I knew it made sense, like sometimes I used to think about his behaviour I did not know at the time but now it does make sense. Like why he did not answer my phone or why he did not want to come out with us. So him sharing his experiences was quite helpful I would say.

Interviewer: I see. Yes it must be a big step for him to take.

Interviewee: Yes absolutely. Also like I said before in some supermarkets we have people with different disabilities and are employed there to pack the shopping bags. It is good I think because it shows us that they can work ad contribute to the society as well. I think there needs to be more effort put into bringing these people into the community.

Interviewer: So you think it is possible for them to contribute to the society?

Interviewee: Of course! I think if they get their treatment and medication regularly they would not be dangerous because medication helps them calm down.' He also noted that 'You know we have a

say in Cyprus keep away from normal people they can be dangerous. I think so too, we now have people killing their fathers, neighbours for no reason. I mean because you have a mental illness does not mean you are dangerous and you are criminal look at the news even people who do not have an illness are very dangerous. So I would not say that mentally ill people are more dangerous than those who are not. I would say they need treatment. People say they are dangerous and they cannot keep a job but I think if they get their treatment they can function normally.

Interviewer: So would you say that in general public still thinks that these individuals are dangerous.

Interviewee: not as much as before but yes I think that these beliefs are still there. Like it is hard to break because they have been around for so long. Like we hear things about individuals killing and being violent to others.

Interviewer: Where do you hear about these things?

Interviewee: They are on the news, on TV like media is very effective.

Interviewer: Is that how individuals with mental illness are being reflected in the media?

Interviewee: Yes. But now we hear less of these.

Interviewer: Can you say more?

Interviewee: Like I do not hear about these as much on the news anymore. May be they changed. But I also know a person with mental illness so I have a different perspective. I think if we increase interaction then we can help reduce negative attitudes towards these individuals. Because when you see these people on TV it is different you think they are dangerous but when you actually interact with them you see a different side of them. You see that they are not that different than us. We have got lots to do but also our government needs to organise events for this to happen because you know how we are unless we have to do it nobody will bother. I also think that professionals can do more, helping these people is not just giving them medication they can also help change attitudes in societies by trying to draw attention to these issues more.

Interviewer: So you believe interaction is a must to change attitudes?

Interviewee: Yes I mean if my friend did not talk to me about it I would not know. I would not have a clue. So interaction is important.

Interviewer: Ok I am going a bit back now. You said that people with mental illness are still being seen as violent (although it is changing). Do you think that females are more threatened by these individuals?

Interviewee: Yes I think so. I mean they are women so they are more sensitive. I would think that they will be more scared.

Intervieweer: What do you mean by sensitive?

Interviewee: Like men have to be tough from a small age. Like boy play with guns girls play with dolls we are tougher. That is why I think they may be more scared.

Interviewer: Ok. You mentioned that interaction can change this, can you think of anything else that can be done to change attitudes?

Interviewee: Hmmmmm. I mean our policies can be better. Like the enforcement of them. If you have the policy enforcement is a must otherwise there is not point of having one. We have policy but I do not know if people obey it really. I myself am a lawyer but I am not sure if we follow it much. Like employers for example nobody can force you to employ someone that you do not want and so employers can show any reason to not to employ mentally ill apart from their illness.

Interviewer: so what do you think should be done?

Interviewee: I think government needs to be stricter about these issues. Make people know their rights and enforce the already existing policies.

Interviewer: ok. Is there anything else you can think of?

Interviewee: No I mean interaction is the most important.

I**nterviewer**: Ok thank you so much for taking your time to participate in this research. Do you have any questions for me?

Interviewee: You are welcome. No questions.

Appendix 10: Pictures showing some of the Coding done on Participants' Interview Transcripts